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# Professional trust in osteopathy: a theory for educational practice

By

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A thesis submitted in partial fulfilment of the degree of Doctor of Education  
(EdD) in the Centre for Research in Education and Educational Technology  
(CREET) at the Open University,

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## Abstract

This research, exploring a theory of professionalism in osteopathy, comes at an opportune moment when regulation and implications for practice are evolving in healthcare. The study sought to uncover the perceptions of osteopaths, students and patients as to their concept of professionalism and to seek a consensus on what this constitutes in osteopathy. It developed the PIECE theory of professional trust containing five key elements which are mediated by dialogue and touch used by the osteopath. The elements are **P**ersonal approach; **I**nteraction and communication; **E**ngagement and relationships; **C**ustomised approach; **E**mpowerment and education.

Twenty-nine interviews were undertaken using two video vignettes to prompt discussion, three facilitated and three unfacilitated focus groups with individual stakeholder groups followed, with a final focus group of mixed stakeholders to develop the final theory using Constructivist Grounded Theory methodology.

The findings show how the elements of dialogue and touch are key throughout all phases of the osteopathic consultation and to the formation of professional trust in osteopathy. An important implication of these findings is that the values and attitudes are not stand-alone concepts but learnt and enacted within the clinical context, not only for students, but for clinicians throughout their working lives. The research has explored the perceptions of patients who are also learners within the osteopathic consultation. The PIECE learning cycle to build professional trust in osteopathy has been developed to aid educators and students along with the PIECE self-reflection tool for students to learn about professional trust in osteopathy.

Keywords: Professionalism, trust, dialogue, touch, osteopathy, Grounded Theory.

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## Table of Contents

Chapter 1 Introduction .....	7
Research Questions.....	10
Structure of the thesis .....	11
Chapter 2 Literature Review .....	13
Research aims and objectives .....	13
Professionalism .....	15
The definition of professionalism.....	16
The attributes of professionalism .....	18
The scope of the definition .....	21
The teaching and learning of professionalism.....	23
Values and Ethics .....	27
The implications for osteopathy .....	30
Chapter 3 Methodology .....	33
Questionnaire design .....	33
Grounded Theory .....	35
Issues with Grounded Theory .....	36
Rationale for choice of methodology .....	40
Research Journal .....	44
Interviews .....	48
Vignettes .....	49
Focus groups .....	52
Data Analysis .....	53
Chapter 4 Methods .....	56
Pilot study design .....	56
Main study design .....	57
Ethics .....	59
Data Collection .....	65

Chapter 5 Findings .....	70
Pilot study findings .....	70
Main study findings .....	73
Researcher surprise .....	73
The hidden data .....	75
The PIECE Theory of Professional Trust in Osteopathy .....	76
Professional Trust .....	80
The importance of dialogue .....	83
The importance of touch .....	85
Personal Approach .....	87
Interaction and communication .....	96
Engagement and Relationships .....	104
Customised Approach .....	110
Empowerment and Education .....	118
Chapter 6 Discussion .....	123
The PIECE learning cycle to build professional trust in osteopathy .....	139
The PIECE self-reflection tool for students to learn about professional trust .....	143
Chapter 7 Conclusions .....	146
Implications for education .....	147
Implications for recruitment .....	150
Implications for dissemination .....	151
Implications for research practice .....	153
Limitations .....	156
Reflections .....	157
Originality of the thesis .....	160
Summary .....	160
References .....	162
Appendices .....	194

Figure 1 Design for data collection for the main study	57
Figure 2 Mindmap for final focus group	64
Figure 3 Initial key thematic areas	66
Figure 4 Twelve early key themed areas	67
Figure 5 Mindmap of developing themes	78
Figure 6 The PIECE theory of professional trust in osteopathy	79
Figure 7 The PIECE learning cycle to build professional trust in osteopathy	142
Figure 8 The PIECE model: self-reflection tool for students to learn about professional trust	145
Figure 9 Reflexive diary entry 6/2/17	158



## List of Abbreviations

ABIM	American Board of Internal Medicine
BMA	British Medical Association
CPD	Continuing Professional Development
GCC	General Chiropractic Council
GMC	General Medical Council
GOsC	General Osteopathic Council
HCPC	Health and Care Professions Council
NMC	Nursing and Midwifery Council
OPS	Osteopathic Practice Standards
RCP	Royal College of Physicians

## **Chapter 1 Introduction**

Professionalism is an important component of medical and healthcare practice which spans all areas of practice and can affect outcomes. As a practising osteopath, an educator in an osteopathic educational institution and a sometime osteopathic patient, I have been fascinated by how students and osteopaths learn and enact professionalism. I wondered whether this was brought to the profession via practitioners' previous life experiences or whether it was formed during the transition from novice practitioner to qualified osteopath and I also wondered whether the professionalism that osteopaths portray is similar to that in other healthcare spheres or whether there are any differences. There does not seem to have been any prior published research in this field within osteopathy and hence there appears to be no baseline understanding of what professionalism *means* to osteopaths, students or patients in osteopathy at this time. I therefore decided to use this study to explore a theory of professionalism in osteopathy to understand how it is enacted and experienced to help support teaching and learning. I believe it is important to understand how the concept of professionalism evolves in students and osteopaths through their experiences in the teaching clinic and onwards in practice, and by capturing the patient experience of professionalism in action, thereby being able to include this understanding in my own teaching of students.

Osteopathy is a relatively 'new' profession that has only been professionally regulated in the last 25 years. It is considered a 'complementary' or 'alternative' therapy that sits outside the standard medical model, but functions alongside it as an alternative therapeutic intervention. However, from deep-seated holistic roots, the profession has started to become more medicalised in its attempt to seek credibility and acceptance. The osteopathic degree course at my Institution can be completed full-time in three and a half years, or over five years on a part-time basis. The curriculum spans medical modules (for example anatomy, physiology, neurology, pathophysiology) and incorporates osteopathy specific modules containing technique, theory and philosophy starting in the first year and progressing throughout the curriculum. The course follows a spiral curriculum with clear progression of theoretical and practical knowledge and skills which are assessed throughout the year and also at the

end of each academic year. The development of clinical experience is evidenced by the requirement for a minimum number of hours within the teaching clinic at each stage of the course with assessments via two clinic reports each year. Students attend clinic from the first year and their attendance requirement in hours increases throughout the course. The total clinical experience hours required throughout the course of study for the Bachelor of Osteopathy Award is 1000 hours, for the Master of Osteopathy Award the criteria is 1200 hours. Each module at every level of the course is designed to reflect the clinical interactions of a student interfacing with a patient to help support the knowledge and ability to become a safe and ethical practitioner. Multiple teaching and learning approaches are utilised from problem-solving, observation of others, reflection in and on action, alongside more formal written examinations. Students are given opportunities to develop key skills such as self-awareness and self-appraisal from the start of the course to aid their development as reflective practitioners. Assessment takes many forms and the diversity of the assessment framework is designed to facilitate students' abilities to perform effectively, to enable demonstration of knowledge and skills related to the learning outcomes and to mirror clinical practice where possible in order to provide a link to the context in which practice happens.

The curriculum is mapped closely to the Osteopathic Practice Standards (General Osteopathic Council 2012) which are the standards set by the regulator to which all osteopaths work. Regulatory bodies for all healthcare modalities issue Standards of Practice for their registered members (Chartered Society of Physiotherapy, 2012; General Chiropractic Council, 2016; Health and Care Professions Council, 2012). These are similar to the Osteopathic Practice Standards (General Osteopathic Council, 2012) except for the fundamental delineation of 'Professionalism' that occurs as a key standard and chapter heading within the osteopathic standards. The remit of professionalism is less overt in other professions' Standards of Practice – certainly evident, but not as a 'standard' on its own. This absorption into other areas is interesting in light of a 233% increase in fitness to practice cases over the last decade (Professional Standards Authority, 2018) and the key focus on 'professional lapses' in practice (General Osteopathic Council, 2017). This lack of parity between Standards of Practice between therapies concurs with debate in recent

research that there is a lack of consensus in the definition of professionalism within the professions (Stockley and Forbes, 2014; Passi et al., 2010; Van Mook et al., 2009; Van De Camp et al., 2004).

Professionalism is a key area of practice which, when adhered to, promotes best practice, but when not can lead to complaints and fitness to practice actions (Yates, 2014; Bahaziq and Crosby, 2011). There has been an 88% increase in referrals to the General Osteopathic Council (GOsC) Fitness to Practice Board from 2015-16 to 2016-17 (General Osteopathic Council, 2017) and many of these hearings have been in areas of the Osteopathic Practice Standards under the section of 'Professionalism' and it is this which is causing concern and around which the basis for this research grew. It is my opinion, that if we can improve the understanding of professionalism in students, through education, based on a dialogue and construction of a theory between osteopaths, students and patients, that the practitioners of tomorrow should have an enhanced understanding of what professionalism means and be able to put this into practice more effectively.

In order to do this I decided to explore the beliefs and values of osteopaths, students and patients as to what professionalism means to the individual within osteopathic practice. This has been undertaken in other healthcare spheres (Evans, 2014; Van Mook et al., 2009; Van De Camp et al., 2004) but it appears that the sociocultural context within which the practitioner learns and practices is important in the formation of and continued learning experiences for the individual (Van Mook et al., 2009; Webster Wright, 2009; Van De Camp et al., 2004).

Beliefs are defined as "something one accepts as true or real; a firmly held opinion" and values as "principles or standards of behaviour; one's judgement of what is important in life" (Oxford Dictionary, 2015). These core principles are evident in all areas of human existence, are sometimes individual yet sometimes shared and frequently context laden (Dreyfus and Dreyfus, 1986). They are fluid, constantly changing perspectives from within the individual, shaped by experience and social change (Rogers, 1961) and this fluidity can be impeded by outside factors. As discussed by Schön (1987), where value

conflicts occur within professions amongst practitioners these are further complicated by increasing pressure from regulation and increased expectations from society.

### Research Questions

Researchers have discussed the constant evolution of professionalism influenced by changes in society and the political arena so that as these cultural shifts occur, so do the constructs of professionalism (Gaiser, 2009). Bryden et al. (2010 p.1027) concur by describing professionalism as “a concept in flux” and Evans (2014) claims that the perceptions people have within their roles in practice are inevitably changed by these fluctuations. Beliefs and values are intrinsic to each individual and create a unique window to explore the world. They underlie the core of human behaviour and mediate the decisions and approaches we undertake in life (Rassin, 2008). Lave and Wenger (1991) created the concept of ‘communities of practice’ in which participants learn through social interaction and participation, while Billett (2001 p.446) discusses workplace learning as a development of workers “ontogenies” influenced by “relational, embedded, reciprocal and pertinent characteristics”. These are individuals’ personal histories that they bring to their roles and which affect how they participate in the social workplace. This study intends to explore the osteopathic community of practice to uncover an understanding of how professionalism is experienced and practised.

The research questions were:

- How do the beliefs and values of osteopaths, students and patients form their individual concept of osteopathic professionalism?
- Is there a consensus of osteopathic professionalism amongst all stakeholders in the osteopathic remit?
- How does an osteopathic theory of professionalism compare with those of other healthcare modalities?
- How can the theory of professionalism be taught to student osteopaths?

### Structure of the thesis

This thesis follows the journey I undertook in exploring a theory of professionalism in osteopathy:

Chapter 2 will present a literature review into the search for a definition of professionalism within healthcare and the discussion surrounding the concepts of values, beliefs, attitudes and behaviours. The sociocultural context of practice will be discussed and the educational implications for the teaching and learning of professionalism.

Chapter 3 will provide a methodological review of Grounded Theory and the debate around its use, issues of reflexivity and the use of research journals. It will also describe the use of interviews and focus groups as tools for capturing in-depth information and underlying perceptions. The use of vignettes will be explored and the role of mindmaps in developing theory.

Chapter 4 will report the design of the pilot and main studies in order to explore professionalism within osteopathy, and the ethical considerations that were acknowledged and undertaken. The data collection schedule and tools for analysis of the data will be presented.

Chapter 5 will chronicle the findings of the pilot study and explain the final theory which emerged from this research: the PIECE theory of professional trust in osteopathy, which was gathered from the full exploration of the data.

Chapter 6 will provide a discussion on the findings, related to my research questions and linked to theory and research. The PIECE theory of professional trust in osteopathy will be explored, alongside the PIECE learning cycle for professional trust in osteopathy and the PIECE theory self-reflection tool for students to learn about professional trust.

Chapter 7 contains my conclusions and reflections on the research and the doctoral journey, alongside implications for osteopathic practice, teaching and learning and recommendations for further study.

This research aimed to explore an understanding of professionalism in osteopathy in order to be able to prepare and educate students for clinical practice, thus enhancing their formation into secure and respectful practitioners who can provide safe, effective care of patients. It is hoped that this knowledge will support educators in developing teaching practices to nurture students with appropriate capabilities and skills. It may also be useful in the recruitment process to source applicants with appropriate aptitudes and propensities for patient-centred care. The next section provides a review of the literature surrounding the definition of professionalism, current attitudes to teaching and learning of professionalism and implications for values-based recruitment.

## **Chapter 2 Literature Review**

### **Research aims and objectives**

There has been an increasing amount of research into the remit of professionalism within all healthcare spheres in the last two decades. The debate has highlighted a lack of consensus in definition, methods of teaching and assessment, along with a perceived confusion as to whether 'professionalism' differs from one medical specialty to the next (Bryden et al., 2010).

The focus of my study is to understand what constitutes professionalism in osteopathy, which does not seem to have been researched previously, and there are no theoretical or empirical studies to explain this. The review of the literature was undertaken widely in the main medical and healthcare fields as much of the research has shown that the concepts of professionalism are unique to individual healthcare specialties (Bryden et al., 2010; Arnold, 2002). Literature was retrieved in the English language, of a theoretical nature, both quantitative and qualitative, an empirical study or a professional body document. The literature was required to refer to values and attitudes pertaining to professionalism in a healthcare sphere, the definition of these within healthcare professions, and the learning and teaching of professionalism in healthcare education. Any non-medical literature was excluded as the focus was intended to remain on professionalism within the healthcare remit.

A number of critical appraisal tools for assessing the quality of empirical studies were explored. Two particular tools were deemed to have components that captured the quality of studies: the Joanna Briggs Institute Critical Appraisal tool (Joanna Briggs Institute, 2014a) and the Quality in Qualitative Evaluation Framework (Spencer et al., 2003). While the Joanna Briggs tool captured the key major elements, it did not seem to incorporate the underlying contextual themes for exploration of social research that particularly include educational studies, hence aspects of the Spencer et al. tool were included. The core elements were combined together to create a unified tool for this study (Appendix 1, p.190). The Joanna Briggs Critical Appraisal Checklist for Narrative, Expert opinion and text (Joanna Briggs Institute, 2014b) (Appendix 2,



p.192) was used alongside researcher opinion on reading studies to assess their strengths and suitability for inclusion. These combined tools provided categories intrinsic for healthcare research, for example providing a focus for capturing the voices of patients and ensuring that their interests were a priority within the research (Appendix 3, p.193).

The rationale for using both was that each tool contained components to capture the quality of studies, but individually did not have the capacity to fully explore all the remit of sociological, educational and healthcare literature. Since the scope of the literature review crossed a wide range of fields, I felt that in order to assess the quality of the literature and its suitability for developing an understanding of professionalism in both the main healthcare remit but also in the smaller osteopathic field, it was important to be able to ensure that the research was sufficiently applicable and relevant. As a large focus of this research is into the importance of context, and also in an under-researched profession such as osteopathy, it was germane to ensure that the literature was rigorous and likely to be generalisable to another healthcare field, or at least to be able to be used to explore this. As this is an educational piece of research aimed at providing knowledge to aid teaching and learning, this too was a factor to be taken into account in assessing the quality of the literature, to ensure that this spotlight on understanding the subject with an educational focus and goal was maintained.

Altogether 317 documents were retrieved, 173 were excluded after reading the abstracts, 73 empirical and 71 theoretical studies were assessed using the critical appraisal frameworks. Some grey literature, in the form of policy documents, was also uncovered which included regulatory and report documents from professional bodies (e.g. General Osteopathic Council, British Medical Association, Health and Care Professions Council, Nursing and Midwifery Council).

The combined empirical and theoretical literature were read and appraised against the combined critical appraisal frameworks using an Excel spreadsheet to annotate the quality components. This allowed the development of understanding of content and quality which informed the inclusion of relevant

literature within this research study alongside appropriateness of related themes to the osteopathic sphere.

The search terminology may have lacked focus as the breadth of the concept of professionalism required exploration of a number of components, such as the definition, understanding of terminology and the range of values, attitudes and behaviours. It is possible that some research may have been missed during this search as some keywords may not have been included. This has been mitigated to some extent by assessing reference lists within studies and exploring the citations to each. A further literature search was undertaken after data collection to capture literature relating to unfolding areas as the research progressed.

A research decision was made early on to target literature that was focal to the medicine and healthcare fields which involved professions dealing with patient interactions involving clinical decision making and including touch. This narrowed the literature search to fields of practice which would be more fully related to the osteopathic remit where clinical diagnostic processes and a hands-on approach are paramount.

### Professionalism

In exploring the literature there appears to have been an increasing interest in professionalism in many healthcare spheres over the last two decades. This has partly been due to increased scrutiny by regulatory bodies and the general public due to changes in society's expectations (Cruess et al., 2010) and organisational and cultural changes (Hordichuk et al., 2015), yet there has still been no consensus of definition for professionalism in healthcare (Bryden et al., 2010). There have been guidelines drawn up within various medical spheres which incorporate similar, although not identical, components (Nursing and Midwifery Council, 2015; General Medical Council, 2013; General Osteopathic Council, 2012; Royal College of Physicians, 2005; American Board of Internal Medicine: Project Medical Professionalism, 2002); however these have been criticised as being externally imposed by regulatory bodies, without the input of practitioners (Evans, 2008) or as difficult to put into practice (Bryden et al., 2010).

Reaching a definition of professionalism in healthcare has proved problematic for a number of reasons. Firstly, there has been debate as to who the definition should be created by and to whom it is targeted. Secondly, there has been disagreement between practitioners on achieving a consensus definition regarding which attributes should be incorporated. Thirdly, there has been disagreement as to the scope of the definition with regards to whether there should be 'one' definition of professionalism within medicine and associated healthcare spheres or whether individual definitions are required for particular healthcare contexts due to their differences of practice. Finally, there has been a debate as to how the definition should be created in order that it can be embedded, taught and learnt within educational institutions and thereby develop practitioners with appropriate and effective skills on entry to the professions.

#### The definition of professionalism

The notion of professionalism stems from the concept of a profession where a collection of individuals is seen to have specialist knowledge or skills which they perform in autonomous practice (Freidson, 2001). Historically, how a profession represented itself was via a collective identity which was also how it presented itself to society (Gaiser, 2009). Irvine (2001) argues that this has since changed due to the need for practitioners to develop and maintain the trust of the general public. Zijlstra-Shaw et al. (2011) also cite increasing expectations from the public in terms of health delivery and quality of care but they discuss the tensions between creating a normative definition versus an ideological one. They claim that any definition needs to encompass both concepts due to contextual and individual differences in practice. However, Van Mook et al. (2009a) state that some of the components of professionalism, for example compassion, are non-cognitive in nature, which makes a normative definition problematic and the authors therefore promote a person-centred approach. Rassin (2008) claims that there is a conflict in constructing a definition that is equally amenable to individuals, the identity of the profession, institutional regulations and to society, but Jotterand (2005) claims that the definition needs to be part of a medical-wide professional moral philosophy which contains agreed values. So the debate as to whether this requires a profession-wide, a societal, or a person-centred approach does not appear to

be resolved. Perhaps by exploring for whom the definition is intended might illuminate the debate.

Wagner et al. (2007) raise the question of who the target audience is for a definition of professionalism and state that it is key to incorporate their input into its creation. In recent times, regulatory bodies have produced guidelines on professionalism that have been created by professionals and educators in the field, but largely written *by* the profession *for* the profession. Hamilton (2008) relates the historical paternalistic structure of medicine with autonomy and control and cites an ongoing “renegotiation of the social contract” (p.105), and there is evidence of public involvement in regulatory change (Irvine 2001). However, Jha et al. (2006) claim that this appears to be limited to ‘lay’ people on committees without evidence of how representative their voice is of the public as a whole. Much of the dialogue surrounding professionalism and the subsequent debate on teaching and learning, appears to have been between professionals and educators to support students and new graduates. This dialogue is intra-professional – it does not include the views of patients who are the end service users. Wiggins et al. (2009) state that patients’ viewpoints are still often neglected and this lack of public voice is an interesting gap as changes in society’s expectations have been key in shaping modern professionalism and spurring the quest for a new definition (Hilton and Southgate, 2007) alongside the current pursuit of patient-centred care (Schubert et al., 2008).

It therefore appears important to create a definition that is accessible to all stakeholders at every point of the educational spectrum, from novice to experienced practitioner at all developmental stages, using language that is understood by all. The need for the patient voice is imperative in providing an indication of the quality of care, as not only can feedback from patients help shape and enhance medical practice (Abadel and Hattab, 2014, Wiggins et al., 2009), but the patient as end user is arguably the expert on whether a practitioner has behaved professionally towards them (Schubert et al., 2008). However, the voice of students is equally important and Baernstein et al. (2009) state that their perceptions and ideas can influence the concept of professionalism and should be recognised and valued, particularly with regards

to their educational experiences, and this will be discussed in the fourth debate on teaching and learning professionalism later in this chapter.

The debate surrounding whether the definition should be created by individuals, practitioners, the general public or regulatory authorities is still not clear, neither is there a clear consensus on how normative and ideological definitions can be combined or quite who the definition should be developed for. The current emphasis on developing patient trust, as mentioned by Irvine (2001), should therefore include their input into the dialogue, and although this is developing there appears to be some distance to go in order to fully include their voices into the debate. In the meantime, regulatory bodies and key stakeholders in the profession appear to be the key proponents in developing definitions.

### The attributes of professionalism

The second major area of disagreement encompassed what the attributes of professionalism should be and how these should be defined. Recent attempts at creating a definition have primarily been formed of lists of attributes and behaviours deemed to frame the professional practitioner (Passi et al., 2010). The construction of these definitions of professionalism have been developed using various elements, from values, attitudes, and behaviours to qualities of character appropriate for a healthcare professional (Birden et al., 2014). However there has been difficulty in reaching a consensus as to *which* values, attitudes or behaviours are essential (Krain and Lavelle, 2009). There have been claims that the meaning of these constructs varies between not only the same types of practitioners (e.g. anaesthetists; Kearney, 2005), but also between healthcare roles (e.g. doctors versus other specialty doctors/nurses; Bryden et al., 2010).

There have been a number of studies exploring individual facets of professionalism using constructs of beliefs (Wagner et al., 2007), values (Aguilar et al., 2012; Rassin, 2008), attitudes (Archer et al., 2008; Rees and Knight, 2007) and behaviour (Green et al., 2009; Schubert et al., 2008) or a combination of these (Stephenson et al., 2006; Purkerson Hammer, 2000). Values are described as learned criteria that provide a standpoint towards what we believe is good or worthwhile (Rassin, 2008); beliefs are deemed to be a

hypothesis or personal viewpoint towards a particular concept; attitudes as learned predispositions that frame a way of thinking, and behaviour as the actions and method in which one conducts oneself (Hammer et al., 2003).

Aguilar et al. (2011) discuss how values can capture the underlying philanthropic tenets but are difficult to identify and assess. Attitudes are deemed easier to measure through scales yet are complex in structure, while behaviours are more overt and therefore easier to assess but can appear superficial. The attempt to explore professionalism 'in reverse' by looking to see how it can be assessed is equally problematic as values and attitudes are subtle complex constructs that are difficult to uncover during assessment processes (Ginsburg et al., 2009) and behaviours do not appear to be reliable under examination conditions (Brown and Ferrill, 2009). There appear to be strengths and weaknesses within each of these constructs and the weight placed on each of these has varied over the last two decades.

Researchers have set out to explore behaviours as an indicator of professional practice as these were deemed to be overtly demonstrable and would enable appropriate conduct to be observed (Irvine, 2001) and make assessment more visible and feasible (Cruess and Cruess, 2012). Rogers and Ballantyne (2010) suggested the need for a tightly defined definition around professional behaviour to which curricula could be mapped and therefore enable clear assessment. However, Shapiro et al. (2015) state that students sometimes portray a superficial impression of behaviour which does not match their underlying beliefs and that providing behavioural guidelines can be potentially restrictive in committing practitioners into prescribed conduct. Van Mook et al. (2009a) agree claiming that behaviours do not always provide a true indicator of inner attitudinal values, while Rees and Knight (2007) are concerned that observing behaviours is problematic as they frequently do not take into account key contextual factors. Martimianakis et al. (2009) agree with this and state that lists of qualities or behaviours do not take into account the underlying reasons for observed professional behaviour.

The argument that assessment of professionalism through behaviours is deemed unsuitable to the sociological framing of modern medical practice has

led researchers to investigate individuals' values that predispose their beliefs and attitudes to situations, and which then influence their behaviour (Aguilar et al., 2012). If behaviour is not always a reliable expression of practitioners' professionalism, Ginsburg et al. (2004) state that it is vital to take into account the contextual implications in order to gain a fully rounded understanding underlying a practitioner's conduct and Aguilar et al. (2012) agree that it is vital to capture elements of practice which may influence how a practitioner performs within individual contexts.

Due to the perceived problems with defining professionalism by behaviours a number of researchers explored the remit of values and attitudes in exploring a definition of professionalism (Waugh et al., 2014; Chandratilake et al., 2012; Schafheutle et al., 2012). These studies have taken into account societal changes and incorporated political, ethical and environment specific attributes in order to seek greater contextual depth for a definition. The main criticism of exploring values, beliefs and attitudes have been their elusive nature (Hordichuk et al., 2015; Bryden et al., 2010) and researchers have found that participants have difficulty in articulating and expressing these (Schafheutle et al., 2012). Abstract values and attributes have different meanings to individual stakeholders and are subtle terms which do not have conclusive definitions, therefore developing an understanding of these requires transferring them into practice and exploring their meaning within context (Shapiro et al., 2015). As values and beliefs can vary within areas of society, they can have diverging levels of importance to individuals and nuanced levels of significance which can sometimes lead to value conflicts (Rassin, 2008). In this way values and attitudes are important to uncover in order to explore how they influence the concept and enactment of professionalism and attempts have been made to explore these constructs by using tools such as vignettes (Bernabeo et al., 2013), peer assessment (Krain and Lavelle, 2009), self-reflection and exploration of practice (Aguilar et al., 2012). These studies have proven effective in uncovering deeply held beliefs and values that practitioners hold on an individual level, but also on profession-wide levels and this has been important for developing more effective ways of teaching and learning about professionalism (Bernabeo et al., 2013).

The debate continues as to the quality of each constituent in encapsulating the essence of professionalism and their utility for teaching and assessment purposes. While each construct has shown benefit in exploring a definition of professionalism it is generally argued that each of these appears too narrow in itself to cover such a wide remit (Gaiser, 2009, Jha et al., 2006), or encapsulate the concept of professionalism alone (Martimianakis et al., 2009).

#### The scope of the definition

The third theme of debate surrounds whether there should be one standard definition of professionalism within healthcare, or whether nuanced versions are required for different healthcare specialties. Despite the multidimensional nature of professionalism there has been a call for a framework that can be used broadly across medical specialties (Van de Camp et al., 2004). However current definitions do not appear to acknowledge the unique beliefs and values that appear within diverse professional areas, and the contextually important differences between these. In osteopathy, practitioners use their hands to diagnose musculoskeletal dysfunction and then treat it. The importance of having skill with palpation and the ability to perform effective treatments, alongside the ability to touch a patient's body with expertise and a level of dexterity appears important to practitioners (Tyreman, 2008). The sociological framing of modern healthcare practice suggests that practitioners co-construct knowledge and develop their understanding and enactment of professionalism with others in the practice context (Webster-Wright, 2009) and this links to Billett's (2001) concept of the connection between knowing and the world in which learning is undertaken. Professionals learn by actively engaging with others in their individual practice environments. Hordichuk et al. (2015) claim that a list of traits or behaviours is insufficient to describe the contextual nature of a multitude of working environments. Birden et al. (2014) disagree and claim that defining professionalism in isolation from other spheres sacrifices common themes and content and becomes too reductionist. This debate has also evolved as to whether the developing definition of professionalism should be fostered around the individual practitioner identity or whether it should be representative of the collective contextual identity (Hilton & Slotnick, 2005). Van Mook et al. (2009a) claim it should take into account the individual vocational role and call for the definition to be sufficiently practice-oriented for the



individual to be able to apply it within the context of their own practice and this appears important in enabling practitioners to make working sense of a definition (Aguilar et al., 2012). While many definitions are largely theoretical rather than directly focused to practice (Van Mook et al., 2009a), Brown and Ferrill (2009) state that it is critical that practitioners can transpose these effectively. Healthcare practice requires adaptation and a fluid approach to each individual patient encounter, and this potentially makes theoretical guidelines problematic. Inflexible and prescriptive guidelines can lead practitioners to feel oppressed by requirements and unable to fit these to practice (Irvine, 2001). The sphere within which each professional works therefore appears important by its individual identity and demands. There has been an attempt to address this in the UK in part by a set of specific appropriate behaviours (Health and Care Professions Council 2014) which encompass the practitioner's sense of self, underlying values and ability to adapt these in practice.

While there is still a lack of consensus on whether the definition of professionalism is centred on the individual or a collective group, there have also been claims that it is not a fixed entity. Bryden et al. (2010 p.1027) argue that professionalism is not a 'static concept' which indicates the need for practitioners to constantly adapt and translate professionalism across contexts and cultures. Cruess et al. (2010 p.373) also describe professionalism as having an 'aspirational character' which hints that it not only has a fluid state but that it is a continual process of adapting and improving practice. This links to Evans' (2014) theory of professional learning in practice where learning is often implicit and frequently unanticipated and can lead to individual micro-level professional development specific to the individual practitioner and their experiences in practice. This is particularly pertinent for the fluid area of medical practice which can often be unpredictable and also leads to the notion that learning through practice is not just about changing behaviour but changing attitudes towards practice.

Within the debate about the contextual importance for professionalism, it appears to be necessary to expand the definition to take into account the aspects of language and the diversity of culture. The lack of a shared language

between stakeholders, for example in this study osteopaths, students and patients, creates a difficulty in translating definitions into comprehensible terminology that can be used in the educational system (Sehiralti et al., 2010) and developed to enhance communication with patients (Wagner et al., 2007). Language incorporates naming objects and concepts, and these become associated with particular words, but the meanings of these can vary to different people (Wear and Kuczewski, 2004) and this is potentially an issue when teaching students who do not yet have a full understanding of practice (Jha et al., 2014). Some of the literature discusses the discourse and language of professionalism (Monrouxe et al., 2011; Wear and Kuczewski, 2004) and this appears to be a key element limiting the formation of a definition.

Cultural elements are also important within the definition of professionalism in making the professional role accessible to all (Shapiro et al., 2015) in terms of acknowledging alternative points of view and influences of varying culture. This is increasingly important in the recruitment of international students and practitioners and the wide array of patients seeking medical care (Jha et al., 2014). This is not only diversity through nationality, but generational differences (LeDuc and Kotzer, 2009) and gender (Hordichuk et al., 2015) among others.

The debate has led to the understanding that core tenets of professionalism are shared between healthcare practitioners and fields of practice, yet there may be nuances to different healthcare spheres. A definition needs to be clearly practice-oriented to allow individual practitioners to utilise it easily in practice and be able to apply it to varying practice presentations. There is also a need for the definition to be accessible and embedded in novice practitioners so that it carries forward into the profession as the next section will discuss.

#### The teaching and learning of professionalism

The fourth theme encompasses how a definition of medical professionalism should be taught and learnt in educational institutions and the importance of continual life-long learning for practitioners. The first aspect surrounds how learning is developed, particularly in a subject area which requires developing levels of expertise in a multiple range of skills evidenced by the array of professionalism competencies. These are also required to be undertaken in the

demanding environment of clinical practice which can often require students to react to situations and adapt their approach to varying contexts.

There is much research discussing the learning of 'professionalism' as being a stepwise, structured process where skills and knowledge are developed sequentially (Dreyfus and Dreyfus, 1986). This describes how learners develop skills through learning and practice in a systematic fashion to acquire skill at varying levels from novice to expert. However others question this and claim individual and social factors strongly influence the intuitive, learning of professionalism (Evans, 2014; Billett, 2010; Webster-Wright, 2009). Dall'Alba and Sandberg (2006) claim the progression in training is non-linear, dependent on context and an embodied understanding of what is required in each interaction. This depicts a skilled level of expertise. Arnold (2002) questions whether different levels of professionalism should be expected from students, new graduates or skilled professionals, dependent on their level of exposure and experience. Hilton and Slotnick (2005) discuss how professionalism is a state that is reached after many years of learning and consider the length of time it may take newly qualified graduates to achieve the skills and experience to gain full professional status. Van Mook et al. (2009b p98) also discuss the transformation of the medical student from "lay person to medical student", but this is criticised by Michalec (2012) as he claims that students inevitably enter medical training with preconceptions and some element of prior knowledge. Dall'Alba and Barnacle (2007 p.682) also explore the concept of learners as "historical creatures" primed by prior experiences in life and society which therefore underscores their perspectives. This opens the debate further as to how prior values and attitudes influence learners' journeys through medical education and the development of their professional practice (Michalec, 2012). Generational differences have also been seen between experienced practitioners, educators and students in medical school where expectations of today's students are different from those of doctors who trained decades before in terms of technological knowledge and expectations of flexibility of working life (Smith, 2005). There appears to be a lack of consensus as to what students bring to professional practice and how this can shape their learning in the practice environment.

The teaching and learning of professionalism in medical and healthcare curricula appears to occur both formally and informally, within structured sessions and within the teaching clinical environment as evidenced through the 'hidden curriculum' Gaiser (2009). The hidden curriculum is defined as, 'the way in which cultural values and attitudes are transmitted through the structure of teaching' (Oxford English Dictionary, 2016).

Formal teaching approaches of professionalism encompass a wide variety of tools from clear mission statements, early orientation sessions for new students and ongoing support within the practice environment (Purkerson Hammer, 2000), group discussion sessions, problem solving and peer interaction (Gaiser, 2009). Recent research has shown that students do not always value the formal teaching of professionalism (Stockley and Forbes, 2014), preferring the intuitive and challenging environment of the teaching clinic. Moreover, the quality of professionalism encountered in this environment is not always optimal as students sometimes observe unprofessional behaviour from faculty which can influence their perception of how to behave or what constitutes acceptable behaviour in practice (Gofton and Regehr, 2006). While institutions design curricula to provide breadth and scope of teaching and learning opportunities, students often value most the unscheduled intuitive learning that emerges through the informal curriculum, largely within the teaching clinics (Baernstein et al., 2009). They seek professional role models in the clinical faculty and their peers and it is these which often have great influence (Hunter and Cook, 2018).

It appears to be the case that what institutions expect they provide, what educators actually provide and what students receive varies (Hammer et al., 2003). There is an increasing understanding that professionalism is not a static entity, as it is dependent on each individual context and human encounter (Bryden et al., 2010) and undertaken within the context of individual practice (Dall'Alba and Sandberg, 2006). The strength of learning within the practical environment in healthcare provides the student not just with information, but with knowledge of 'becoming' a practitioner (Dall'Alba and Barnacle, 2007) and learning from effective role models in the clinical environment is particularly influential (Schafheutle et al., 2012). Yet research has shown that students are sometimes misguided by inappropriate role-modelling and receive mixed

messages throughout their educational journey (Gaiser, 2009). It would seem that in order to support this learning, clinical educators need to be provided with clear guidelines and expectations of behaviour (Stockley and Forbes, 2014; Gaiser, 2009), supported with enhancing reflection in and on action (Bernabeo et al., 2013) and developing inter and intraprofessional discussion to support this (Birden et al., 2014).

Research also indicates that faculty need to be engaged in the discussion and development of assessment practices. Attempts to assess professionalism out of context or in stand-alone examination procedures do not appear to produce valuable or reliable results (Zijlstra-Shaw et al., 2012). Observing students in simulated practical assessments does not reproduce a true practice environment and students appear to perform how they expect will gain them a good mark (Brown and Ferrill, 2009). Equally, when assessing through case-based scenarios, students seem likely to give the answer they think will gain them marks, rather than what they would do in practice (Rees and Knight, 2007). Rating scales for observed practical performance have shown little reliability between examiners (Arnold, 2002) leading to the suggestion that no single tool may be adequate in exploring professionalism. The discussion indicates that in order to develop professionalism, formal assessment is deeply important in providing students with feedback in order to improve practice and develop their skills (Ginsburg et al., 2000). However, summative assessment of professionalism is vital to ensure that novice practitioners are gaining the requisite skills and professing appropriate behaviours at each stage of the professional journey (Webster-Wright, 2009). This is particularly important for patient trust and for institutions to be able to declare that students meet the standards required for entry to the profession (Van Mook et al., 2009a). There appears to be a need for this to be undertaken using multiple instruments to measure important elements of professionalism which take into account contextual issues (Arnold, 2002) and which enable the novice practitioner to perform these skills within the practice environment where they are enacting the professional role (Dall'Alba and Barnacle, 2007). This is achieved most effectively in the clinical practice environment with observation over longer periods of time to enable faculty to observe a wide range of performance in context. The need for multiple learning and assessment tools is vital in order for

students to optimise learning opportunities and be able to fully express their professionalism in practice. This will also enable educators and assessors to reassure themselves that the learning of professionalism is successful and inform any necessary changes to teaching and learning strategies.

The learning and development of professionalism skills does not end at graduation but continues throughout the professional life of a practitioner. Webster Wright (2009) discusses continual professional learning as a “lived experience of continuing to learn as a professional” (p.715) where learning cannot be separated from the experience of practice and the interactions undertaken within that context. The dynamic nature of practice requires practitioners at any stage of their career to continually reflect on and improve their approach to practice (Mackey, 2014). This is particularly relevant in connection with the arguments from other researchers who claim that society is continually changing and therefore the understanding of professionalism must adapt with this (Bryden et al., 2010; Gaiser, 2009).

### Values and Ethics

The issue of professionalism has increasingly become more pertinent, partly due to the failings in care provided to patients in recent times, evidenced by increased mortality rates and poor care levels within the Mid Staffordshire NHS Hospital Trust (Lord Francis, 2013). The Government responded to this (Department of Health, 2013) with a call to action for improvement which led to the Berwick Report (2013) that provided recommendations for accelerating improvement of care within the National Health Service (NHS) in the United Kingdom. It also prompted the Keogh Report (2013) that reviewed the quality of care and treatment provided in NHS Trusts that persistently showed high mortality indicators and the Lord Willis Report (2015) that provides 34 recommendations for the enhancement of education and training for nurses and healthcare assistants. Within these recommendations are elements incorporating the patient and public voice alongside value statements and opportunities to promote learning and research (Lord Willis, 2015). This has resulted in the publication of new standards for the pre-registration education of nursing students and trainee nursing associates (Nursing and Midwifery Council, 2018a and 2018b).

Whether these recommendations will combat the historical disagreement as to what actually constitutes professional behaviour and the difficulties inherent within complex situational contexts remains to be seen, and I believe that a greater awareness of these issues, an increased focus and a profession-wide dialogue will lead to positive change. There have been indications that underdeveloped professional attitudes can lead to incidences of unprofessional characteristics (Santen and Hemphill, 2011; Brown and Ferrill, 2009; O'Sullivan and Toohey, 2008; Stephenson et al., 2006) and evidence of unprofessional behaviour has been discovered in many reviews, but also in overt behaviours of students and faculty, from mild infringements to more serious fitness to practice issues (Yates, 2014; Papadakis et al., 2005). Research implies that poor behaviour as a student can link to poor professional behaviour once qualified (Papadakis et al., 2005), yet these links have not been sufficiently identified and do not always lead to subsequent misconduct (Yates and James, 2010). However, despite how small the numbers this intensifies the call for greater screening on entry to the professions.

Values Based Recruitment has been established as a tool designed to attract and recruit students and employees who express the values, attitudes and behaviours that align with those within the NHS (Health Education England, 2016). It has set a challenge to educators to find an appropriate measurement tool to recruit staff and students with values that match the ethos of the organisation and who will enhance patient care (Tuckett, 2015; Miller and Bird, 2014; Pitt et al., 2014; Waugh et al., 2014,).

The Francis Inquiry (2013) explored the area of 'resilience' as a key area that was perceived to be vital to professionalism. Resilience is defined as the ability to maintain positive adaptation despite experiencing situations of adversity (Herrman et al., 2011). Modern healthcare is frequently epitomised by a lack of support for practitioners under increasing work pressures (Tuckett, 2015) who require mechanisms of support to enable resilience (Stephenson et al., 2006). There has been research based on practitioners' and students' experiences in practice but it does not explore the potential values gap between professionals and patients, yet the latter are the stakeholders accepting care (Rankin, 2013).

Without further investigation and action to address this there may remain a gap between stakeholders' expectations which may create further tensions.

Osteopathic practitioners are not bound by fixed time constraints in their consultation length or requirements for availability for patients as they generally work in private practice and decide on the length of consultation time and have freedom in the number of hours worked. Due to the nature of many osteopaths working alone in private practice it is unknown what support mechanisms are available to them or to which they seek recourse. This research hopes to uncover practitioners' experiences of professionalism and the pressures and difficulties surrounding this.

The connection between professionalism and ethics is subtle but essential (Zijlstra-Shaw et al., 2011). Elements such as 'whistle-blowing' are taught and debated on ethics courses and are also a requirement of professionalism (Rogers and Ballantyne, 2010) and there are many links between the two areas, for example patient advocacy and interpersonal relationships. Practitioners are required to meet both governing body and stakeholder expectations which can lead to professional dilemmas but the divide between ethics and professionalism, where each stands alone, is currently unclear (Worthington, 2015). Healthcare practitioners are expected to act in the public interest and are therefore scrutinised by public and professional bodies, these latter imposing standards onto the professions (Evans, 2008). Practitioners, whether qualified or student, are required to report unprofessional behaviour but many are reluctant due to emotional burdens or fear of ramifications (Milligan et al., 2017). Others with under-developed ethical skills may not acknowledge errors or bad practice (O'Sullivan and Toohey, 2008) while some students find it very difficult to take difficult decisions. There is a question as to the level of support that is provided to students in healthcare educational institutions to enable them to develop a balanced, professional perspective for when these incidents occur (Ginsburg et al., 2003). Martimianakis et al. (2009) argue that regulatory frameworks take away the autonomy of the professional role, yet professional status requires regular and substantial re-regulation in order to withstand the scrutiny of public and political examination (Hillis and Grigg, 2015). This scrutiny provides a powerful tool to bring about change (Mackey, 2014) but this approach is criticised by Hafferty and Castellani (2010) who



argue that the hierarchical approach is outdated and that shared and effective decision-making within the healthcare team is far more appropriate.

Professionalism, however, is increasingly deemed to have an external focus where its purpose is not so much to serve doctors but to protect the public (Worthington, 2015). Regulatory bodies oversee the professions and they are frequently viewed by members of the professions as gatekeepers who define rigid standards and provide authoritarian guidance to practice (Chard et al., 2006). Analysing patient complaints can give a window on what the public object to in practice (Rogers and Ballantyne, 2010), but these do not always make clear the specific observable behaviours, do not capture the full contextual underlying reasons behind the behaviour and do not take into account the complexity of particularly problematic areas of professionalism in which practitioners may find greater challenges. This potentially adds to the debate on who is involved in deciding what constitutes professional behaviour: the public, the regulatory authority, the profession, the individual professional or the patient - or a mixture of all.

#### The implications for osteopathy

The literature has shown that there is still no fully agreed or defined consensus on what constitutes professionalism in healthcare, nor a clear focus on what constructs to use in order to achieve this. The lack of agreement on definition has also left regulatory bodies to provide varying Standards of Practice to the professions. There also appears to be no gold standard for teaching or learning of professionalism in healthcare education, although research has indicated some useful tools for this, and the assessment of professionalism also remains problematic. Each sphere of healthcare has its own unique form of delivery in terms of types of contact with patients and nuances of therapy delivered, which potentially require individual approaches. As there does not appear to have been any investigation into the remit of professionalism in osteopathy, an exploration of the values and attitudes through the perceptions of osteopathic practitioners, students and patients is needed. This will enable the construction of a context-specific understanding on which to further explore opportunities for teaching and learning professionalism within the profession.

In my role overseeing the educational delivery within a teaching clinic at an osteopathic educational institution I am ideally placed to investigate, develop and implement enhanced teaching and learning strategies to improve staff and student understanding of professionalism in order to improve the care that patients receive. I have long believed that multiple tools of learning should be explored and utilised to enable students with a wide range of learning needs to be able to access knowledge and skills and that educational tools which require active learning are most effective, for example group discussion of case-based scenarios, role-playing in pairs or small groups and discussion on self-reflection of clinical experience. These tools enable learning *with* others and learning *from* others which are invaluable in exploring different mechanisms of practice and developing skills. At my osteopathic educational institution first year students are required to attend clinic to observe senior students' interactions with patients. As part of their clinical learning, first year students are required to undertake a written reflection of their observations at each visit. These prove to be powerful tools to stimulate early reflection and enable students to understand the diversity of clinic experiences. These reflections are continued at each academic stage and provide a personal resource of development of learning and achievement.

In order to explore stakeholders' perceptions a social-constructivist perspective was required to understand the experiences of professionalism in osteopathy of all stakeholders, from the layperson (patient), through the osteopathic educational process (how a student chooses osteopathy as a profession through to their educational experience) and how knowledge of professionalism is supported, developed and enhanced through to practitioner status. It required an understanding of the uniqueness of osteopathy to enable a practice-based understanding to develop. My research questions were:

1. How do the beliefs and values of osteopaths, students and patients form their individual concept of osteopathic professionalism?
2. Is there a consensus of osteopathic professionalism amongst all stakeholders in the osteopathic remit?
3. How does an osteopathic theory of professionalism compare with those of other healthcare modalities?

#### 4. How can the theory of professionalism be taught to student osteopaths?

The research into professionalism has indicated that an exploration of values and attitudes is most likely to uncover participants' deeply held views on professionalism. The next chapter outlines my choice of methodology and design for uncovering these perceptions in order to seek an understanding of what constitutes professionalism in osteopathy.

### **Chapter 3 Methodology**

This study set out to seek osteopaths', students' and patients' perceptions of what constitutes professionalism in osteopathic practice. My initial research questions were designed to explore how the beliefs and values of osteopaths, students and patients form their individual concept of osteopathic professionalism and whether there is a consensus of osteopathic professionalism amongst all stakeholders in the osteopathic remit. I also wanted to explore how a theory of osteopathic professionalism might compare with those of other healthcare modalities. Finally, my intent was to use the information to design teaching and learning strategies to enable this new knowledge of professionalism to be taught to student osteopaths and enable experienced practitioners to improve their practice.

The initial literature review provided an insight into the complex array of perspectives within many fields. The issue of who a definition is for, and who should contribute to it, is interesting as it pre-empts the construction of a definition. The importance of the findings in previous research that professionalism appears to have unique meanings and importance to different healthcare specialities (Martimianakis et al., 2009; Dall'Alba and Sandberg, 2006) has led this search for new knowledge in osteopathy.

In order to explore an initial understanding of the values and attitudes which are important to osteopaths, students and patients in osteopathy, I undertook a pilot study using an online questionnaire in order to assess the strength of agreement with these, whether they represented the facets appropriate to professionalism in the osteopathic sphere and whether there were any additional values or attitudes specific to osteopathy. The rationale for using an online questionnaire is outlined next.

#### **Questionnaire design**

Questionnaires are a popular form of survey tool which are commonly used to capture participants' knowledge or attitudes towards a subject (Boynton and Greenhalgh, 2004). They can be self-administered or interviewer-administered dependent on the purpose and type of information that is required (Saunders et

al., 2012). Online questionnaires have become increasingly popular due to ease of delivery (via email or link to a website), less expensive in terms of paper and postage cost, and are easy for participants to respond to (Fan and Yan 2010). However, Gray (2014) cautions that there are security issues regarding web-based questionnaires as it is not always clear who has accessed the survey and this can potentially compromise validity. He also states that certain demographic parts of the population may not be as technologically competent to access them and this can also produce sampling error.

In my pilot study, I was keen to explore participants' perspectives of how deeply important they felt values and attitudes were to professionalism in osteopathy. I wanted to explore a number of participants' opinions, provide them with anonymity in giving their responses and be able to compare the strength of consensus or dissensus. By capturing a range of views by using a rating scale where participants indicate how strongly they agree or disagree with a particular statement, I hoped to build a baseline understanding of the values and attitudes which were important in preparation for the main study. A Likert scale provides the opportunity to generate opinion but also transfer the information into a numerical scale on which statistical testing can be undertaken. The Kruskal-Wallis test is a non-parametric (where data is not distributed normally) analysis of variance between three or more groups and suitable to be used in exploring the results from the three stakeholder groups in my pilot study (Cohen et al., 2007). They state that rating scales do not presume equal intervals between the rating categories, therefore it is difficult to assess true strength of opinion. Also, participants tend to avoid the extremities of the scale and opt for a mid-point rather than be seen to express very strong opinions. They suggest using even-numbered scales with no mid-point or extending the number of rating options.

The length of questionnaires is cited as one of the biggest reasons for non-completion (Kelley et al., 2003). Rolstad et al. (2011) claim that shortening the length of surveys may affect validity and reliability in terms of providing a limited scope and not being sensitive to differences between responses. They claim that the length of questionnaire should be determined by the subject under study and Gray (2014) states that they should be used appropriate to the

objective of the research. The questions contained in questionnaires need to be clear, succinct and avoid bias (Fan and Yan, 2010). However, as an initial tool to provide a basic knowledge of the values and attitudes prevalent in osteopathic practice, the online questionnaire appeared appropriate.

Once information had been captured from the pilot study I decided to use Grounded Theory to explore what professionalism means to osteopaths, students and patients in osteopathy. This could have implications both for myself as a researcher, practitioner and educator, but also for all participants in bringing to the fore their understanding of the concept and re-evaluating their perceptions during the process of generating a theory.

### Grounded Theory

Grounded Theory was instigated by Glaser and Strauss in the 1960s as a qualitative method for generating theory in social research (Cutcliffe and Harder, 2012). This developed around the need for a 'real world' approach to applied sociological research whereby theories are generated from data rather than verifying existent theories (Glaser and Strauss, 1967). It allows theory to inductively form a conceptualisation of the main problem (Kenny and Fourie, 2014; Glaser, 2010) and renders the processes for theory generation visible (Bryant and Charmaz, 2007).

There are a number of unique components to Grounded Theory: data collection and analysis occurring simultaneously and a constant comparative process, whereby the researcher repeats the process alongside memo writing until data saturation is reached (Kenny and Fourie, 2014). Coding is used where initial categories and their properties are formed and these are supported by conceptual memos whereby a researcher notes their thoughts on potential theoretical notions for further investigation (Glaser and Strauss, 1967). The continual comparison of codes and incidents results in the generation of a theory that is only limited by saturation of gathered information (where incoming data only reinforces what is already captured). Glaser and Strauss describe the constant comparative process in four stages: comparing incidents within the data, integrating these, demarcating the theories and writing these up. The entire Grounded Theory process emphasises the analytical and developmental

processes as equal to the results of the research (Charmaz, 2008a) and it is this that distinguishes Grounded Theory from other research methods (Glaser, 2010).

The evolution of Grounded Theory caused disagreement between the two founders. Glaser maintained the original perspective of 'Classic' Grounded Theory, while Strauss, along with Corbin, refined a perception of the method - 'Straussian Grounded Theory' - using more analytical and prescriptive frameworks for coding (Kenny and Fourie, 2014; Strauss and Corbin, 1990) which take it away from the original format of Grounded Theory (Evans, 2013; Jones and Alony, 2011). A further evolution of Grounded Theory - 'Constructivist Grounded Theory' - emerged proposed by Charmaz (2014) who interpreted it into the constructivist paradigm whereby theories are co-constructions of knowledge between researcher and participant. It has been argued that this process produces greatly differing theories from those elicited from the original Grounded Theory (Higginbottom and Lauridsen, 2014) while Glaser (2002, p.3) refuted the constructivist approach stating that it resulted in purely "descriptive capture".

Glaser and Strauss acknowledged that their initial presentation of Grounded Theory could evolve over time (Cutcliffe and Harder, 2012) and it has been argued that these evolutions have moved with changes in qualitative research (Mills et al., 2006; Greckhamer and Koro-Ljungberg, 2005). Grounded Theory has been used with a variety of underlying epistemologies and it is open to this adaptation (Reed and Runquist, 2007; Mills et al., 2006). Glaser and Strauss' initial Grounded Theory did not cite an underlying paradigm yet it is this and the coding conventions that appear to delineate the different versions of Grounded Theory. Classic Grounded Theory aims to discover an emergent theory, Straussian Grounded Theory contains coding structures to create rather than discover a theory, while Constructivist Grounded Theory is directed to construct a conceptual interpretation of the data (Kenny and Fourie, 2015).

### Issues with Grounded Theory

There have been numerous criticisms of Grounded Theory ranging from its claims to theory development (Thomas and James, 2006), methods of coding

(Babchuk, 2010; Charmaz, 2008a), a restrictive analytical process (Evans, 2013; Thomson, 2013; Boychuk Duchser and Morgan, 2004), complexity for novice researchers (Cooney, 2011), limitations for natural generation of a theory (Evans, 2013; Jones and Alony, 2011; Charmaz, 2008a), not to mention the disagreements between the founders as to the true method (Glaser 2010; 2002).

Thomas and James (2006) claim that Grounded Theory does not reach beyond the creation of everyday assumptions. Glaser (2002) claims that Grounded Theory is a conceptual method that transcends abstraction using an iterative, cyclical process which promotes rigour (Ryan-Nicholls and Will, 2009; Carter and Little, 2007) as outlined by the constant comparative process (Nagel et al., 2015) raising the conceptual level of the study. The inclusion of participants in validating the data through these processes (Ryan-Nicholls and Will, 2009), on an individual level and through focus groups in my study was intended to provide strength in the development of a theory.

Thomas and James (2006) question the researcher's objectivity from the data and Roberts et al., (2006) state there is a need for transparency in the decision-making process. Glaser (2010) claims that biases are revealed by the constant comparative process and claims that the emergence, rather than forcing of a theory, promotes rigour. This is a problem for Constructivist researchers who immerse themselves within participants' narratives (Mills et al., 2006), report data in narrative form (Glaser, 2002) and are deemed to construct rather than discover concepts (Andrews, 2012). Guba and Lincoln (1981) state that complete objectivity is impossible to achieve, Charmaz (2008a) and Bunniss and Kelly (2010) state that the process is never neutral, and I agree with these statements. The research process needs to be transparent, so that underlying values can be acknowledged by both researcher and audience (Mills et al., 2006) and determine adequacy of the emerging theory (Cooney, 2011). However, there appears to be an element of trust in researchers in achieving such transparency (Hammersley, 2007) and to retain sufficient detail to aid the reader in reaching understanding (Morse, 2004). This, then, might provide the Constructivist researcher the ability to contextualise and enrich the data by allowing participants to refine and develop the emerging theory (Chiovitti and



Piran, 2003). Encouraging active participation of participants promotes reciprocity and an obligation to contribute to learning (Faden et al., 2013) and achieves a theory using terminology accessible to the audience (Hammersley, 2007). These concepts are important in my research where stakeholders were encouraged to actively generate the theory, provide further engagement through individual member-checking and discussing growing theory in focus groups in the final stages.

There is a criticism of entering the research arena without prior knowledge (Goldkuhl and Cronholm, 2010; Thomas and James, 2006). Disclosing prior information is a priority when undertaking Grounded Theory (Jones and Alony, 2011), influences must be made implicit in the research process (Charmaz, 2008a), while others consider this can be minimised through careful planning and reflexivity by using memo-writing (Giles et al., 2013). Prior knowledge does not appear to be the problem, but what the researcher does with this, and Glaser's concern appears to be that an early literature review may taint the process (Dunne, 2011). However, the literature review can have many benefits in providing fundamental knowledge (Dunne, 2011), while Cutcliffe (2000) argues that prior knowledge is a positive factor in allowing creativity into the analytical process. It is my belief that my knowledge and preconceptions should be mapped as deeply as the participant data to make clear any impact on the emerging theory.

The proposed use of Grounded Theory has limited, to some degree, the formation of research questions for this study due to the methodological process of allowing the generation of data to follow its own inherent course (Glaser and Strauss, 1967). Key proponents of Grounded Theory have stated that research questions should merely set a boundary to the research area and allow a frame in which to explore and develop a theory (Strauss and Corbin, 1990). They also suggest that the initial research question should be broad, that this will naturally narrow during the course of the research and should focus on one key area of interest within the context to be studied. With this in mind, the initial question that formed, based on the findings from my Pilot Study was:

How is professionalism experienced by all stakeholders in osteopathy?

The exploratory nature of Grounded Theory might enable exploration of the relevancy and uniqueness of context to participants (Glaser and Strauss, 1967), and to shed light on the research question in uncovering the perceptions of stakeholders and any unresolved tensions between these. As I wanted to uncover key concepts for each participant group to provide insight as to what professionalism means within osteopathy, whether the perceptions of stakeholder groups are similar and how all involved can be educated to understand this concept better, Grounded Theory appeared to be an appropriate vehicle.

There have been a number of studies within the field of professionalism in healthcare which cite using Grounded Theory as a methodology, although in many studies the form of Grounded Theory is not cited, appears unclear, or the researchers state that 'a Grounded Theory approach' has been used (Santen and Hemphill, 2011; Bryden et al., 2010; Park et al., 2010). A table of these studies is provided in Appendix 4 (p.194) with an indication of the likely forms of Grounded Theory inferred from each study if not overtly stated. The Grounded Theory research into healthcare and professionalism has used a broad array of versions, although few give a rationale for their choice. Three PhD studies (Thomson, 2013; Andersen, 2008; Flynn, 2007) were explored for their rationale for using Grounded Theory, two of which chose Classic Grounded Theory and one Constructivist Grounded Theory. Each gave a good explication of the reasons for their choice, but the study that chose Constructivist Grounded Theory resonated with me. The reasons for their choice echoed my previous concerns that Straussian Grounded Theory constricts by the rules of coding, hinders the analytical process and produces an explanation of behaviour rather than a generation of theory (Andersen, 2008; Flynn, 2007). Thomson (2013) claims that Constructivist Grounded Theory is more congruent with an osteopathic perspective and states that within his role as researcher/practitioner he also could not maintain a detached approach. I concur that it is necessary to be reflexive on the insider/outsider interaction. Thomson also states that Constructivist Grounded Theory allows multiple voices to be heard which is important in generation of a theory amongst a number of stakeholders and

many of the health professions are turning towards this methodology (Thomson et al., 2014; Kennedy and Lingard, 2006) due to its underlying framework.

#### Rationale for choice of methodology

I initially felt drawn to the early form of Classic Grounded Theory due to its ability to allow theory to emerge naturally from the data and as there has been apparently no research into professionalism in the osteopathic remit the use of Grounded Theory is appropriate for generating theory in this area. Grounded Theory is also used widely in sociological and healthcare fields and is useful for providing elucidation in educational and professional settings (Thomson et al., 2011). Other methodologies could explore perceptions and identify collective features but would not take the extra step of generating theory, yet the inductive process inherent in Grounded Theory would advance this (Evans, 2013).

I felt that Constructivist Grounded Theory might lose the focus of the theory that is generated through the data to merely an emphasis on participants' experiences and stories (Breckenridge et al., 2012). My concern was that it might become an attempt at relaying the 'stories' of stakeholders' experiences rather than developing a deeper understanding of the meaning behind these. While it lays an emphasis on rich reflective data (Ghezeliyeh and Emami, 2009) I was unsure how the process of researcher involvement in the construction and analysis of theory might unfold. I was concerned as to how my previous and current experience in all stakeholder roles should be taken into account in this research and that impact from these should not be allowed to direct the research process. Although insider knowledge can have immense positive power in research, in the case of Grounded Theory and particularly in this uncharted field, I felt it was important that the theory should be generated as much as possible from others' voices and perceptions rather than be 'skewed' by my own opinion. I was concerned that the underlying philosophical underpinning of how knowledge is created in the osteopathic field should be explored through Classic Grounded Theory by capturing a unique and authentic theory through the data, rather than by producing an *interpretation* of stakeholders' perceptions of this.

I decided against Straussian Grounded Theory, which is cited as having a more restrictive analytical process (Evans, 2013; Thomson, 2013) that is complicated for novice researchers (Cooney, 2010) and limits natural generation of a theory (Evans, 2013; Jones and Alony, 2011; Charmaz, 2008). The Straussian approach argues that the theory derived is both generated and verified within the data (Evans, 2013) which appears to be not only a brave assertion but goes against the underlying concepts of allowing theory to emerge (Boyчук Duchscher and Morgan, 2004). The less structured Classic version of Grounded Theory allows theory to emerge more naturally through the data collection process without being restricted to focal methods of sorting and categorising information.

My intent was to allow a theory to emerge from all stakeholders in osteopathy that would illuminate a better understanding of stakeholders' beliefs, values and attitudes and how these form their concept of professionalism in osteopathy and whether there is a consensus understanding of osteopathic professionalism. However, on further exploration of these varying methodologies, my positioning changed.

I realised that Constructivist Grounded Theory provides an ability to locate the research process strongly within a social and situational domain (Charmaz, 2016) which is particularly pertinent in exploring an osteopathic remit. As an osteopath and educator myself, Guba and Lincoln's argument (1994), that research findings created through interaction between the inquirer and participants are more plausible, resonated with me. I was becoming aware of my role in the research and despite Glaser's (2002) declarations that bias within the study is countered by the constant comparative process, I strongly believe that it is not possible to remove my own influence from the research and feel, instead, that it is something to be aware of, declared, and embraced. Charmaz (2008a) states that research always reflects value positions and states it is imperative to remain conscious of researcher positionality throughout the process (Charmaz, 2016), while Hammersley (2007) states researchers should aim to be neutral, which Guba and Lincoln (1981) state is impossible to achieve. Hellawell (2006) asks for researcher scrutiny in relation to their position and claims they should be both inside and outside the process. Some

critics discuss a tension within insider versus outsider positioning (Brunero et al., 2015; Hanson, 2013) whereas others see it as flexible (Labaree, 2002) and allowing the release of multiple meanings (Chavez 2008). My position as an insider/outsider researcher was quite complicated as I was inside the research as a practitioner, educator and patient, yet outside as a researcher and this required reflexivity. This is described as a complex concept for reflection on the research process (Lambert et al., 2010) and is commonly used as a tool in Grounded Theory studies in order to demonstrate transparency in the research process and allow the reader to explore the potential impact of the researcher on the study (Engward and Davis, 2015).

While Glaser (2002) advocates distance and objectivity from the researcher, Charmaz (2008a) promotes integration and understanding in order to see the world from the participants' viewpoints. Constructivist Grounded Theory locates the research in historical, social and situational conditions (Charmaz, 2016) which enhances the importance of context which is key to my study within osteopathy. It allows the issues to emerge from the stories and explanations that the participants tell (Kenny and Fourie, 2015; Mills et al., 2006), lays an emphasis on rich reflective data (Ghezeliheh and Emami, 2009) and allows co-construction of understanding between researcher and participants (Charmaz, 2014). Critics of this state that it blurs the lines between scientific discovery and narrative writing (Hammersley, 2007), becomes a descriptive endeavour (Glaser, 2002) or risks becoming the researcher's rendition rather than true to participants' accounts (Ong, 2012). It is therefore important to transparently account for each stage of the research process and provide clarity on researcher interactions, influences and development of data and theory (Gentles et al., 2014). This requires taking a reflexive approach to the research process and Attia and Edge (2017) discuss how reflexivity can be used both prospectively in terms of how the researcher affects the research endeavour and retrospectively where the researcher records their influence on the research. This is echoed by Brannick and Coghlan (2007) who claim there are two forms of reflexivity: one methodological form monitoring for impact on the research process, and the other epistemic which exposes the researcher's own belief systems. In this research I have used both forms, firstly in exploring my impact through ethical decision making and positioning in the research process

and also throughout the undertaking of the research through memo writing in exploring my impact on the process and the effect on myself as a practitioner and researcher. The ability of reflexivity to stop the researcher in their tracks and disrupt the process is a powerful tool (Ashmore, 1994) which may create discomfort, alongside the researcher uncovering struggles with role conflict (Corbin Dwyer and Buckle, 2009), or lacking self-knowledge and thereby only undertaking a partial reflexive process (Cutcliffe, 2003). The researcher's position has been argued to be fluid, hence the stance of the researcher at any given time requires awareness alongside any potential implications on the research (Berger, 2013). This is potentially important in my own study in Grounded Theory in tracking my thought process through the iterations of interviews and focus groups alongside theoretical reading.

The position of the researcher on the research continuum is defined by many factors, for example access, acceptance and opportunity (Greene, 2014). It is argued there is a tension between the benefits of being an insider researcher with knowledge and awareness of potential subtle nuances, versus the outsider researcher who has the freedom from prior knowledge and arguably a greater chance of objectivity (Hellowell, 2006). There are potential risks of the insider exploring tacit knowledge (Cutcliffe, 2003) in the sense of personal intuition and private experience and insights, but this position may also reveal new perspectives which might not be accessible to the outsider (Labaree, 2002). In my own research I have been both inside and outside the research in my position as an osteopath and an interested party to the concept of professionalism, but an outsider to the osteopaths who I line manage, the students I teach and patients I treat. These mixed levels of interaction and engagement have required differentiation and adaptability in my approach to each stakeholder group alongside a reflexive approach.

Issues of power have historically been important in qualitative research in the social sciences and how the researcher interacts with participants and power is shared on many levels (Pillow, 2003; Finlay, 2002). There have been claims that the researcher's voice can block out other voices due to an unequal power relationship (Berger, 2013; Pillow, 2003), the subjective bias of the researcher presuming prior knowledge over the researched (Greene, 2014), leading to the

researcher overshadowing the participant (Finlay, 2002). There is a potential problem with distinction between participants' roles, particularly in the healthcare sphere which could become distorted (Karnieli-Miller et al., 2009) where one participant shifts from being practitioner to researcher, or patient to researched. These provide ethical issues that need particular care and consideration within the qualitative research process. When undertaking research requiring co-construction of theory, this is a particular issue whereby disclosure of information from either the researcher or participant might lead to tension or potentially affect trust (Probst, 2015).

The terminology describing roles in the research is also an interesting indicator of perceptions of power and can provide an insight into how researchers perceive the roles of participants within the research process (Karnieli-Miller et al., 2009). In my own research I term the three participant groups as 'stakeholders' as I view them as equal to myself in their construction of knowledge on professionalism in osteopathy. My intent has been to work alongside participants in uncovering an understanding of what professionalism means in osteopathy but also by learning alongside participants throughout the process and developing educational tools to disseminate this knowledge. However, it has been important to ensure that I document the development of the research process and the development of the growing theory to ensure that it was continually linked and developed iteratively from the research process. One of the methods I used for this was to keep a research journal which will be discussed next.

### Research Journal

My own perspectives have been inevitably bound within the construction of meaning as I am a practising osteopath, have studied osteopathy and am involved in osteopathic education so I have many prior conceptions garnered from my experience over the years. It has therefore been important to show how theory has been constructed and interpreted through the data collection and analysis processes taking clear account of my own beliefs and preconceptions. This reflexivity required taking into account all potential influences (Bunniss and Kelly, 2010) to what Bryant and Charmaz (2007, p.46) term "theoretical accountability". Research journals can be used to help situate

practice (Pillow, 2003), explore and deal with the relationship between the researcher and the researched (Brannick and Coghlan, 2007), make clear the subjective nature and interpretation of data by indicating a decision trail (Jasper, 2005) and provide a form of self-appraisal by turning the researcher lens onto the self (Berger, 2013). A reflexive approach provides the means for creating a repository for thoughts, emerging discoveries and questions that arise through the process and record these for analysis (Gerstl-Pepin and Patrizio, 2009). This can aid development of understanding, the ability to develop criticality and show changes in focus or direction within the research process (Jasper, 2005).

There are many tools for reflexivity in research ranging from reflective journals, member checks, peer debriefing (Gerstl-Pepin and Patrizio, 2009), research diaries (Hellawell, 2006), repeated interviews, audit trails of analysis and building theory (Berger, 2013). This can be at a *sectional* level or as an awareness of the whole research process and it needs to be specific to the research endeavour (Bolam et al., 2003). Jasper (2005) discusses how reflective writing can produce both primary data in the form of logs or journals which capture the research process, and secondary data in the form of reflective accounts which are personal accounts of the process. Attia and Edge (2017) discuss how this can be used both prospectively in terms of how the researcher affects the research endeavour and retrospectively where the researcher is influenced by the research to record the reflexivity. So it can be seen that reflexivity by keeping a journal, in and of itself, provides a means to explore the researcher's role in the process from a variety of directions.

However, it has been argued that often researchers claim to use reflexivity without fully describing how it has been undertaken (Pillow, 2003). This is important where the position of the researcher affects major aspects such as access to the field, the nature of relationships and the researcher's own worldview (Berger, 2013). The ability of reflexivity to stop the researcher in their tracks and disrupt the process is a powerful tool (Ashmore, 1994) which may create discomfort, alongside the researcher uncovering struggles with role conflict (Corbin Dwyer and Buckle, 2009), or lacking self-knowledge and thereby only undertaking a partial reflexive process (Cutcliffe, 2003). But Halliwell (2006) states that reflexive tools can provide the ability to show how



the researcher develops throughout the process, but also provide a window on what participants perceive of the process, therefore almost providing a two-way account but through the researcher lens. Jasper (2005) describes reflective writing as a method in itself as a data source and a specific technique within both a philosophical and theoretical framework. She argues that there is no one objective reality, that knowledge is purely construction according to the author and this can be an asset in reflective writing as it makes clear the stance of the author. By writing in the first person this recognises the author's experience, their centrality in the research field, promotes self-awareness and an internal dialogue (Jasper, 2005). I chose to keep a research journal to document my role in the course of the research as an active process of reflection. This was undertaken throughout the data collection and analysis periods and excerpts can be seen in Chapter 7 and at Appendix 5 (p.195).

With reference to Grounded Theory, Glaser (2002) refuted the need for reflexivity in preference for allowing theory to emerge from the data and although not including reflexivity in the original iteration of Grounded Theory, it was later further developed by Strauss and Corbin although not explicitly defined (Cooney, 2011). This lack of specificity has been criticised by Hall and Callery (2001) who state that data is produced through the creation of meanings in interaction with participants and affected by the nature of that relationship which therefore needs acknowledgement. Charmaz (2008) states that reflexivity is central to the Constructivist version of Grounded Theory and allows researchers to critically examine the research process and how they co-construct knowledge with participants. Finlay (2002) claims that showing how elements interact in knowledge creation is important in the trustworthiness and transparency of research. Cutcliffe (2003, p.144) describes "intellectual entrepreneurship" as a method for accounting for insight gained from the data and suggests the use of spontaneous theoretical memoing can capture these insights to show the structure and direction of the building theory.

Constructivist Grounded Theory as a methodological choice for healthcare research requires reflexivity as a core part of the process (Nagel et al., 2015; Taghipour, 2014). The ability for Constructivist Grounded Theory to explore the experiences of participants enables researchers to discover shared

understandings (Taghipour, 2014) alongside the processes and interactions forming meanings (Thomson et al., 2014) and this has been my choice while investigating perceptions of professionalism of stakeholders within the osteopathic profession.

Charmaz (in Bryant and Charmaz 2007) describes how Constructivist Grounded Theory is an iterative process in which it is vital to explore and chart the interactions between participants in the process and this can allow the reader to assess the quality of the research (Hall and Callery, 2001). This is echoed by McGhee et al. (2007) who used different methods to address their positionality and a priori knowledge in their respective studies in healthcare as an adjunct to the constant comparative method. Using the Grounded Theory tenet of theoretical sensitivity, whereby no new data is captured, alongside reflexivity as a tool to explore the journey undertaken, can enhance the reader's understanding of the production of theory (Hall and Callery, 2001). Advocates of Constructivist Grounded Theory embrace the relativity of the researcher's perspective and advocate reflexivity in an effort to create depictions of social constructions in the world (Charmaz, 2008) and in this way, reflexivity is an important tool in Constructivist Grounded Theory as opposed to the original objectivist approach.

A conceptual framework is core to any study and forms the basis of a research approach (Cutcliffe and Harder, 2012; Mann, 2011); however it may only provide a partial view of reality (Bordage, 2009). I approached this research with a social constructivist stance where I believe there are some objective realities in the world but that knowledge is socially constructed between individuals by co-construction of meaning that alters perceptions and the realities that they experience (Carpiano and Daley, 2006; Guba and Lincoln, 1994) and this can be fluid in time (Hammersley, 2007). Critics state that this fluidity can lead to imprecise use of methodology (Cutcliffe and Harder, 2012), complexity in interpreting meanings (Nagel et al., 2015), alongside issues with reliability (Roberts et al., 2006; Ashmore, 1994). It was therefore imperative to choose a methodology with the ability to adapt to shifting perspectives and variable practice (Hammersley, 2007; Corbin and Strauss, 1990) and to explore how knowledge is constructed by participants (Mann, 2011). This is important

where individuals initially construct personal knowledge that is altered by social experiences (Billett, 1995), to create shared understandings (Lave and Wenger, 1991) in a dynamic process that engages people as agentic learners who build knowledge together (Mann, 2011; Lave and Wenger, 1991). I believe that Grounded Theory had the potential to achieve this in my research by collecting participants' perspectives and generating an understanding of what this means in the context of osteopathic practice. I planned a three-stage approach to the main study, initially by interviewing individual stakeholders, then moving onto individual stakeholder focus groups as data collection finished, with a final mixed stakeholder group to test the final development of a theory. My choices for using interviews and focus groups are explained next.

### Interviews

The research has required exploring differing perspectives, hence social constructions of the meaning of professionalism, initially through talking to stakeholders using in-depth interviewing, exploring participants' perceptions and understanding of the concept of professionalism in osteopathy. There is a criticism that interview does not provide a stable source of data, merely capturing attitudes at a point in time (Hammersley, 2007); however Lave and Wenger (1991) argue that language is a social activity from which knowledge is created, while Berger and Luckmann (1966) also state that conversation is the vehicle for expressing subjective reality. Alshenqeeti (2014) claims that interviews are a powerful tool for eliciting participants' views in depth and exploring the meanings behind these. She also alleges that interviews allow participants to speak in their own voice and express their own thoughts and feelings. This is important in osteopathy where the language used by stakeholders to describe professionalism is important to explore.

Professionalism, being a delicate topic, requires a supportive manner, by meeting participants face to face and providing reassurance in person as to the research intent and ethical issues involved. In-depth one-to-one interviewing can provide the opportunity to attempt to put participants at ease so they feel able to discuss sensitive issues (Dempsey et al., 2016). However, participants can fear identification through participation, risking their own position or those of others, alongside creating distress in discussing issues (Wolgemuth et al., 2014). Awareness of these, listening actively to pick up on any distress, and

flexibility in adapting the approach of the interview to each participant's needs are therefore imperative in ensuring that participants can be involved safely (Dempsey et al., 2016). Researching professionalism using a social constructivist perspective also enables the interview process to act as a collaborative endeavour where the researcher and participant are working together, but with a focus on the experience of the participant (Wolgemuth et al., 2014).

Unstructured interviews, often called narrative interviews, can be useful where complete freedom is needed by both parties to explore areas to be discussed, yet this can limit the quality of data derived if participants explore widely but to less depth. Semi-structured interviews are more common as they provide prompts to guide participants but allow exploration of experience, opinion or knowledge around subject areas (Rosenthal, 2016). As I was aware that professionalism is a wide subject area and often difficult to discuss, I decided to utilise semi-structured interviewing and incorporated short video vignettes as a prompt to aid discussion for the initial stage of the main study. I hoped that by collecting in-depth information from participants individually and face to face that I would be able to explore the key values and attitudes that stakeholders felt were important in osteopathic practice and gain rich experiential stories that would enable understanding to emerge of how it appears in the practice context. The theory behind the use of vignettes as a tool to enable participants to discuss professionalism and explore their experiences is described next.

### Vignettes

Vignettes have been valued as a method of exploring perceptions in difficult to research areas (for example sensitive issues or where circumstances rarely occur in practice) and for the ability to explore underlying perceptions which pre-empt decision making and behaviour choice (Hughes 1998). There has been increasing use of vignettes in sociological and healthcare research over the last two decades (McCleary et al., 2014; O'Dell et al., 2012; Jenkins et al., 2010; Hughes and Hubby, 2004; Hughes, 1998), exploring professionalism in medical healthcare in a variety of ways, from focus group discussions (Bernabeo et al., 2013) to online questionnaires using rating scales (Borrero et al., 2008; O'Sullivan and Toohey, 2008; Boenink et al., 2005; Duke et al., 2005; Goldie et

al., 2004). I wanted to use vignettes as a means of exploring underlying perceptions but also to explore their efficacy within this research with a view to using these as a tool for teaching about professionalism in the future. Vignettes can take many forms, from paper based written case scenarios, to computer generated and produced scenarios, and audio or video vignettes (Hughes, 1998). They allow researchers to explore sensitive areas, offer the participant the ability to disclose or non-disclose information and provide the ability to explore in-depth underlying perceptions, meanings, assumptions and judgements (Østby and Bjørkly, 2011). Written scenarios are claimed to require low cognitive demand, while video vignettes require a greater demand from the participants to draw their own meaning from the overt visual performance allied with the non-visual clues which are unavoidable (Hughes and Huby, 2004) and the choice of presentation is dependent largely on participant group. I felt that video vignettes would be useful in providing a visual presentation alongside aural to capture the full sense of osteopathic practice by providing portrayals of an osteopath and a patient to prompt discussion.

Critics of this method have claimed that vignettes are remote from reality and do not provide the interactive processes which are a necessary part of functioning in everyday life (Hughes, 1998). It could be argued that this detachment from the situation limits the inclusion of the nuances of real-life experiences which impact a participant's engagement and meaning-making. The claim that vignettes are always artificial and not directly comparable to real life is refuted by O'Dell et al. (2012) who claim that it is not the intention to map directly to life but to allow the flexibility for exploring the missing areas which is where participants provide the important data. This is particularly valuable in qualitative research where the richness of the data is valued and where the researcher is frequently allowing the participant to guide the direction of exploration. However, other researchers using quantitative methodologies have aimed to try to 'fit' their vignettes as closely to real-life as possible in order to capture data (Taylor, 2006). It appears to be important that the vignette tool matches the purpose for the study and suits the methodological process (Hughes and Huby, 2004). It also appears to be the responsibility of researchers to apply robust criteria to the development and checking of vignette scenarios to maintain the highest standards of content.

It is also claimed that participants frequently provide separate accounts when challenged by situational vignettes by providing public and private accounts of their perceptions and these are controlled by whether they feel they can open up within the research process (Hughes, 1998). This is a common criticism of the vignette technique as critics claim that what participants say does not match their actual behaviour (Østby and Bjørkly, 2011). O'Dell et al. (2012, p.703) take this a step further by discussing the “dialogicality” implied by the multiple voices within a person’s talk which challenges the concept of a singular reality and requires an interpretation to disentangle the multiple perspectives of a participant’s self and identity.

Bernabeo et al. (2013) used vignettes within focus groups of physicians to stimulate group discussion and reflection on how they interpreted and enacted professionalism in practice. They found that vignettes were a very useful tool that provided interesting scenarios that participants found to easily stimulate discussion and the interaction within the focus groups encouraged reflection at a group level in a socially interactive process. Their findings appeared to be influenced by the interactive process so that individual perceptions were altered by the group dynamics. The researchers found it difficult to follow one person’s train of thought as the focus group was so interactive, participants appeared to be unwilling to judge or challenge others’ views, and it was difficult to make comparisons between the groups as they were so uniquely different in content.

Borrero et al. (2008) chose to explore generational differences in the perceptions of professional behaviour of medical students and teachers using an online questionnaire containing 16 vignettes where participants were asked to rate the severity of each infraction on a 4-point Likert scale. The study showed no generational differences but a wide distribution and variation in responses between all categories and groups indicating a lack of consensus. The study may have been limited by a lack of context provided in the vignettes and the online presentation of the survey and quantitative approach. A similar finding occurred in a study by Boenink et al. (2005) where an online survey was utilised to assess the impact of a new educational curriculum focussed on professional behaviour for medical students. The authors claimed that the

variability of vignettes limited generalisability to new situations and that the absence of rules regarding professionalism limited students' ability to transfer knowledge to new situations.

It therefore appears that vignettes can be a useful tool in research in prompting discussion within the field of professionalism, but their structure and content need to be appropriate to the context and participants under research and they need to be specific to participants' experiences and expectations. In order to ensure the utility of my vignettes I played them to an osteopath, student and patient in advance of the main study, for their feedback to ensure they were unlikely to cause distress to participants and that they were audible, understandable, credible and likely to prompt discussion within the field of professionalism in osteopathy.

For the second and third stages of the main study I decided to utilise focus groups in order to test emerging concepts and ideas on broader groups of stakeholders as part of the constant comparative process, and in the final stage on a mixed focus group of stakeholders to allow these participants to debate and discuss the growing theory.

### Focus groups

Focus groups appear to have emerged from market research in the 1940s where Merton and Lazarsfeld used the method to explore group opinions to wartime radio broadcasts (Kidd and Parshall, 2000). The method developed outside of the academic research arena and therefore does not bind itself to any particular methodology, and it has been used in association with many qualitative approaches (Côté-Arsenault and Morrison-Beedy 2005). They describe its purpose as seeking the opinions of particular groups where a wide range of opinions are sought and anonymity is not required. Jakobsen (2012) states that it is important not to perceive the focus group as the same as a group interview which is more interviewer-led, that it is a completely different modality as the focus group requires participants to question and challenge one another, thereby developing understanding and promoting interaction. The interactions between participants appears to be key and a well created and balanced group can provide rich and useful data (Jayasekara, 2012). However,

there are criticisms of focus groups too, in that there are potential issues of power imbalance between participants and researcher, but also between participants themselves (Jakobsen, 2012). Additional issues could pertain to representation of specific communities of patients or service users such as those from socially disadvantaged groups and for whom English is not their first language. These issues can be mediated to some extent and Rosenthal (2016) states that it is important for the interviewer to ensure attention is focussed on the relationships, while remaining as unobtrusive as possible and allowing participants to be drawn into the discussion so an equal representation of experiences is gained. She states that research questions should be open-ended and neutral in focus to allow clarity and the opportunity to develop a discussion. The issues of power are important and I chose to undertake three unfacilitated focus groups with individual stakeholders in order to enable participants to talk without me, as researcher, present. There is no current indication that focus groups held without a facilitator appear superior (Kidd and Parshall, 2000). A lack of research in this area leaves an unanswered question as to whether power differentials can be affected through this means. Kidd and Parshall (2000) state that participants can be easily side-tracked in focus groups but Côté-Arsenault and Morrison-Beedy (2005) state that the interviewer needs to maintain a focus on the research question in order to mediate for this. Kidd and Parshall (2000) also question whether the individual or the group of participants is the focus of the analysis but discuss how the concept of both is analysed in the data analysis procedure. However Jakobsen (2012) discusses how the role of the researcher is side-lined during the process as the focus is placed strongly on the participants and this aids them as being active participants in the research process. This, in particular, aligns well with Constructivist Grounded Theory and is one of the reasons I chose to use focus groups as part of my research. I also felt that the group dynamic would aid in the constant comparative process of developing and defining themes that emerged from the data in the construction of a theory.

### Data Analysis

Data analysis of the interviews and focus groups was undertaken as an iterative process from the start of data collection in order to capture initial themes, explore the constant comparative process (Glaser and Strauss, 1967) and



attempt to delve for underlying concepts until conceptual saturation was reached. There was a constant process of assessing the quantity and quality of the data in order to make a decision as to whether continued interviewing was required and appropriate. Analysis of the data were undertaken using F4 and F5 transcription and analysis software which was recommended by doctoral researchers. The software enables transcription of audio recordings and subsequent analysis. The transcription component enables including timestamps for easy accessibility and retrieval, while the analysis software enables coding and memo writing which can be compared between documents. The codes can be delineated by using different colours to differentiate within the text. The software also provides the ability to analyse the interviews line by line and highlight sentences or phrases and give a description or code. An initial attempt to analyse the first three interviews line by line seemed to merely provide descriptive analysis so I referred back to Grounded Theory texts (Charmaz, 2014; Bryant and Charmaz, 2007) in order to seek guidance and direction as to how to conceptualise the data collected. This enabled me to review the data and re-start theoretical analysis (Charmaz, 2014).

Whilst this was a useful tool, the scale of the data generated was initially overwhelming and as a visual learner I started to construct mindmaps as a visual tool to explore the data I collected. These enabled me to collate codes into subthemes and group these together to get an understanding of how different areas related to one another. I also tried to use participants' words and phrases verbatim as I not only felt that these were pertinent in drawing attention to key areas, I was also keenly aware that the participants were 'telling the story' of osteopathic professionalism 'in action'. In line with Constructivist Grounded Theory, I was aware that it was important to let these voices come through the data into the construction of the theory. As the interviews and focus groups progressed, I continually analysed the data, defining themes at each stage with mindmaps, re-testing the themes by questioning participants and refining an understanding of the developing theory.

The need for a clear and delineated methodological approach is key in articulating the rationale for the study and providing a rationale for the tools to be used. Utilising Constructivist Grounded Theory provided the ability to

explore perceptions from all stakeholders to develop a theory from their viewpoints and perceptions and allow their voices to narrate an understanding of professionalism in osteopathy. The research design will be explained in further detail in Chapter 4.

## **Chapter 4 Methods**

This research set out to explore the perceptions of professionalism from all stakeholders in osteopathy. This was undertaken through an initial Pilot Study which was aimed at providing preliminary data as to the values and attitudes that osteopaths, students and patients felt were important in the profession to provide a core understanding on which to base the main study. This provided greater understanding of stakeholders perceptions in order to frame the main study which utilised Constructivist Grounded Theory using the means of one-to-one interviews and focus groups to build a theory of professionalism in osteopathy.

The research focussed on understanding what professionalism means to osteopaths, students and patients in the practice context, how this compares to other healthcare fields with the intention of developing tools to enable this new understanding to be taught effectively to novice osteopaths and experienced practitioners in order to enhance the patient encounter.

### **Pilot study design**

An initial pilot study was undertaken to provide a baseline understanding as to what stakeholders in osteopathy perceive as important professional values and attitudes in osteopathy. It also provided a grounding for the main study in providing insights for the creation of the video vignettes which were used to stimulate discussion around the concept of professionalism. I constructed a questionnaire (Appendix 6, p.197) based on an initial literature review of the values and attitudes that have been incorporated into previous research in the medical field in order to compare the osteopathic context: 17 key values were offered followed by 34 attitudes that represented these, placed in a random order. Participants were asked to rate how strongly they agreed with these on an ascending Likert scale with five options for the values and four for the attitudes. The concepts of values are rather more abstract than the statements of attitudes; attitudes have a certain contextual or descriptive nature in that they indicate potential behaviour or action. I decided not to offer participants an option to take the 'middle ground' for the attitudes as I felt it was important that opinions were captured, that participants should have a view of whether or not these were important and that it would help the statistical analysis by providing

either positive or negative data. The responses were adapted into numerical figures and compared using the Kruskal-Wallis test (Gray, 2014) to explore whether there were significant differences between the perceptions of the three groups.

The questionnaire was intended to capture the understanding of professionalism of qualified osteopaths, students and their patients with twenty participants in each group. By defining the responses of these three 'voices' it enabled the construction of an initial understanding of what professionalism meant to these groups, and this information could then be used to inform further investigation intended to explore the sociological framing of these interpretations within osteopathy. Findings from the Pilot Study will be discussed in the next Chapter.

### Main study design

The main study was undertaken in three stages (Figure 1) in order to gradually build concepts and themes from individual interviews; to test these emerging concepts and themes on individual stakeholder focus groups in the constant comparative process; finally to test the emerging theory on a mixed stakeholder focus group.

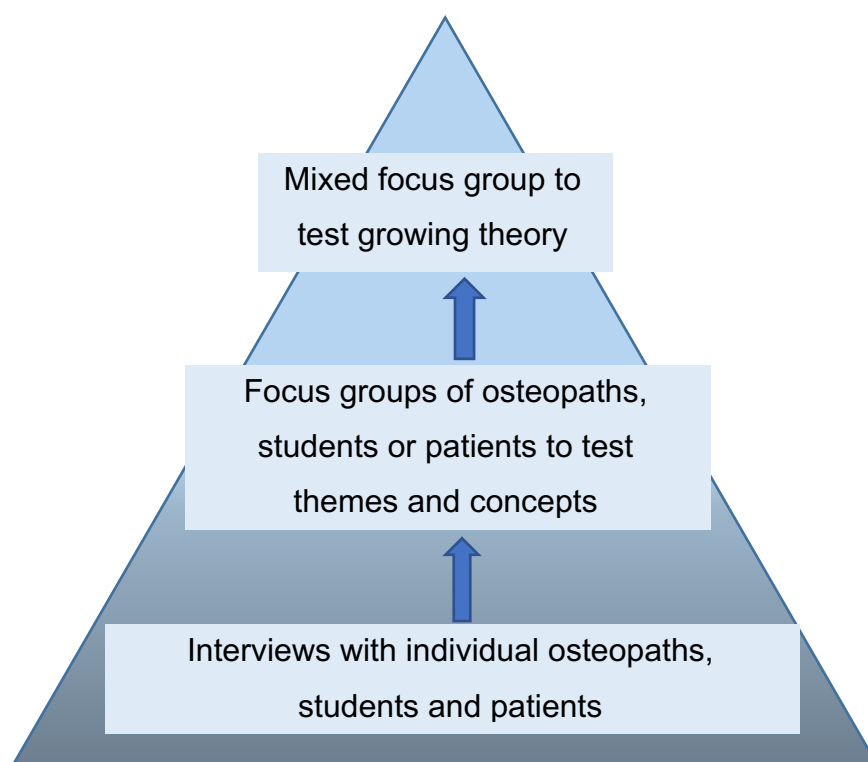


Figure 1 Design for data collection for the main study

On deciding to use vignettes in order to stimulate discussion with participants in my research I wrote two fictional vignette scenarios, one from the narrative perspective of an osteopath, the other from the perspective of a patient. These were designed to incorporate the values gathered from the Pilot Study with some overlapping between the two vignettes (Appendix 7, p.201). The first one incorporated more of the emotional aspects of the values and attitudes from the perspective of an osteopath discussing their thoughts about their practice. The components involved in this were:

Altruism (selflessness)
Caring
Commitment
Compassion
Excellence (professional)
Having good relationships with other healthcare professionals
Lifelong learning (keeping up to date with knowledge and skills)
Listening to patients
Respect
Working as a team with other healthcare professionals
Being reflective
Empathy
Humility
Advocacy

The second vignette incorporated more of the practice related components:

Accountability (to answer for their actions)
Communication
Competence
Working to the Osteopathic Practice Standards (OPS)
Honesty
Integrity (moral principles)
Responsibility to patients

By placing the vignette 'stories' from different participant perspectives I hoped to stimulate discussion immediately from varying viewpoints and allow participants to explore outlooks from other sides. The two vignettes were quality checked by an osteopath, student and patient to ensure that they were visible, audible, understandable, authentic to all participants and appropriate to stimulate discussion. All three reviewers felt they were fit for purpose and no changes were required.

Each vignette was approximately four minutes in length and contained two pause points at key places designed to seek participants' thoughts on what they had just observed in order to explore their perceptions and to allow participants to absorb what they had just watched and give their impressions without overloading them with information.

Each pause point during the videos would enable me to prompt the participant for their perceptions, encourage them to provide opinions on what they had just observed, and to discuss their thoughts and opinions related to their own experience within osteopathy. This also provided spaces for each participant to speak where they felt able to do so and to enable me to pick up on comments made and probe further by repeating back what participants had said in question form or asking them to explain further (Charmaz 2014).

### Ethics

Documentation for ethical approval was submitted to the Human Resources and Ethics Committee at The Open University on 10<sup>th</sup> November 2016. The application required consideration of the ethical needs for all three stakeholder groups over the three stages of data collection: individual interviews, stakeholder focus groups and a final mixed focus group. The initial response from the Ethics Panel required consideration of providing transport for patients to the final focus group and the provision of contact details of an independent person outside of the research group for any participant queries. Insurance cover was provided for transport and an additional research contact from the Open University was sourced and details provided to participants. The required amendments enabled resubmission and full approval was received on 23<sup>rd</sup> December 2016.

Osteopaths who teach at the school of osteopathy where I am employed and fourth and fifth year students at this institution were contacted via their college email addresses via the course leader as gatekeeper. The email contained the relevant Participation Information Form (example provided at Appendix 8, p.207) containing the rationale for the study. The osteopaths included clinic tutors in the teaching clinic and academic staff who teach technique in class. It was made clear to all that there was no obligation to participate and that it had no connection with their employment or academic studies and there would be no ramifications from participation or non-participation. Patients in my own private practice were recruited through advertising by poster in my clinic reception area asking for volunteers to take part in the study. These provided general details of the study and contact details of the researcher. Patients who were interested in participating were freely able to express their interest to me and were then provided with the Patient Information Form. Patients were reassured that not only were they under no obligation to take part, there were no implications for participation or non-participation and it would not affect their ability to seek treatment at the clinic. It was hoped that up to 10 of each stakeholder group would be interviewed to allow for breadth of data collection. The same participant groups were contacted by the same means for each stage of the study. The numbers finally recruited were as follows:

Individual interviews	29 participants (9 osteopaths; 10 students; 10 patients)
Facilitated student focus group	7 students
Facilitated osteopath focus group	6 osteopaths
Facilitated patient focus group	5 patients
Unfacilitated student focus group	9 students
Unfacilitated patient focus group	4 patients
Unfacilitated osteopath focus group	3 osteopaths
Final focus group	6 participants (2 osteopaths; 2 students; 2 patients)

I did not have set numbers I hoped to recruit for the research due to the use of Grounded Theory methodology and the constant comparative process. I initially hoped that 10 of each stakeholder group would suffice for the initial interviews and at least five for each of the individual stakeholder focus groups and two of each stakeholder group for the final focus group.

Participants were provided with a consent form for each stage of the study and advised that participating in the interviews and focus groups constituted informed consent. Participants were informed that they could choose not to participate freely and were able to opt out at any point without their responses being captured, particularly if they were concerned by certain questions asked in interview, by some details within the video vignettes or in discussion in focus groups. Participants were informed that they could contact the researcher, supervisor or independent contact via the details provided in the Participant Information Form to discuss any matters further or would be directed to their General Practitioner with their permission if they needed further psychological care. They were also informed they could contact the General Osteopathic Council if they wished to discuss any concerns with osteopathic care further.

It was imperative that participants were assured that the research would not impact on their relationship with myself, or their connection with the osteopathic educational institution or my private clinic. The participant information documentation clearly stated this and I also reiterated it to all participants at each stage of the research process. I made an attempt to remain alert to participants' discomfort and gained consent for participation in writing, but also verbally, at each stage. I made it very clear that the research was outside my role as an educator or as a practising osteopath. This was a complex balance, as I still engaged with all participants in my other roles, but through reassurance, gaining consent and opening spaces for dialogue I hoped to maintain dual relationships with all parties.

Undertaking research within dual roles is a complex process (Greene 2014) that involves issues of power which can change at varying stages of the process and require researchers to be flexible (McDermid et al 2013). These changes in power relations can arguably alter from the initial stage of recruitment, through



the process of data collection and analysis, to final dissemination of the findings (Karnieli Miller et al 2009). Researchers have described investigators occupying a “space between” embracing the complexity of the role when researching in practice (Corbin Dwyer and Buckle 2009 p.60) limiting the concept of polarisation into a defined positional role and promoting an individual and situational judgement negotiated and defined by those being researched (Labaree 2002).

Interviews with osteopaths and students were undertaken at either of the College’s two teaching sites at a time and place convenient to and agreed by the participant. I made myself available on dates when osteopaths and students were already present at the College site and in order to fit in with their academic commitments. The Senior Management Team at the College enabled provision of a dedicated, private teaching room at both sites in which to conduct the interviews and focus groups which provided privacy and confidentiality. Interviews with patients were undertaken within my private practice at a time convenient to the patient and separate to and outside of the therapeutic osteopathic appointment time. The interviews with patients were scheduled concurrently with patients’ osteopathic appointment times where possible to ensure that no extra travel obligations were required. Food and drink were provided at every interview and focus group. The interviews lasted from 28 minutes to 40 minutes, while the shortest focus group lasted 15 minutes (the unfacilitated osteopath focus group) while the longest focus group lasted 53 minutes (the unfacilitated patient focus group).

For the individual facilitated stakeholder focus groups, questions were developed from the initial interview stage and I posed these questions for the participants to discuss. The questions for the unfacilitated focus groups were written on A3 sheets of paper and provided in the room for participants to use as a guide for exploration. For the final focus group participants were shown a mindmap of the theory to date (Figure 2, p.62) and I gave a short verbal explanation of what had been emerging from the data so far and then provided three questions for participants to explore and expand on during the meeting. The questions for all the focus groups can be seen at Appendix 9 (p.209).

Each interview and focus group was recorded on a dictaphone and on an iPad to ensure that a safe recording was made. These were transcribed at the end of each week using a digital transcription software package 'f5' (Dresing et al., 2015) which enabled the researcher to transcribe verbatim and enabled the insertion of time stamps to quickly access and listen again to each part of the interview. The software package was chosen as recommended by doctoral researchers as it provides the ability to upload digital recordings and transcribe efficiently. Once transcribed, the software enables easy noting of themes using colour coding, the ability to add comments or memos to the text, comparing and filtering quotations or codes and then exporting into Microsoft Word or Excel.

All participants were provided with a transcript of their own individual interview or focus group discussion, at which point they could choose whether any data should be withheld from the study or material added if there was anything else they wanted to say. After this point all transcripts were allocated with pseudonyms so that data in this thesis is anonymous. Two participants provided minor typographical changes (misunderstood words) which were subsequently amended and one participant claimed that two comments in a focus group were made by other participants rather than to the ones indicated. These were checked and amended.

Each transcribed interview and focus group was uploaded onto secure servers at the Open University to preserve the data. The laptop was protected by antivirus software and password protected and kept in a locked room at my home. Only the researcher and the two Doctoral Supervisors had access to the data. The data will be kept for the duration of the EdD study and will be destroyed at the end of this period. The Open University Information Acceptable Use Policy (The Open University, 2012) was adhered to.

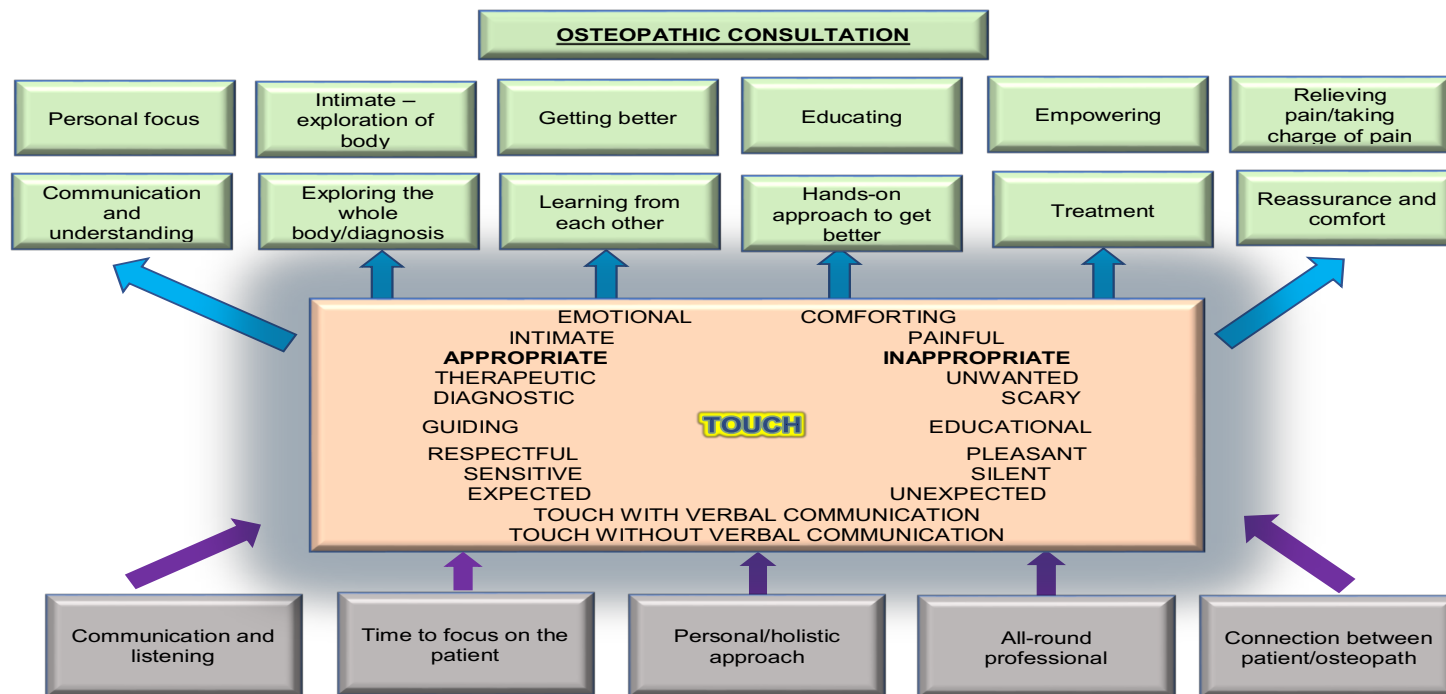


Figure 2 Mindmap for final focus group

### Data Collection

The practicalities of interviewing participants required making myself available to participants at a time convenient to them. I travelled to the College more frequently in order to access osteopath and student participants. I was able to timetable a number of interviews on the same day to enable capturing as much data as possible in one visit. A schedule for the interviews and focus groups is at Appendix 10 (p.210). At the end of the 29th interview all the data were revisited and this resulted in 173 different codes under 35 different themes (Appendix 11, p.213). This information was used to collect key thematic areas (Figure 3, p.64) which enabled me to visually observe the core themes and start to look for connections between areas and draw the data into 12 core categories (Figure 4, p.65). An excerpt from the first interview with a patient, Aileen, showing line by line coding is at Appendix 12, p.218.

The analysis of the data was time consuming and I needed to extend the time period before the final focus group to ensure that key themes captured could be utilised effectively. I transcribed all the data myself as I have accurate and fast typing skills, and this also allowed me to totally immerse myself in the data which also enhanced my reflexivity as I absorbed what participants had said. As a self-employed osteopath I had certain flexibility in scheduling my private work and I also received support from the college where I work part-time to have pre-arranged flexibility in those work hours in order to focus on analysis and writing up the thesis.

<p>Need to feel listened to Treated as human being Osteopath 'understands' Relating to patient Thinking about how patient presents (Ost model) Therapeutic relationship Non-judgemental Not over-familiar Honesty – explanation Good communication Empathy support communication information ACKNOWLEDGING <i>Mutual</i> trust <i>Mutual</i> respect Communication lines open Sensitivity Take patient seriously – build confidence Not 'caring' – 'being concerned' Taking the patient's feelings into account Supportive and caring Building relationships with patients over the course of their lives Be a constant in peoples' lives Feeling safe Building rapport and trust More 'in tune' – see more frequently Looking for similar ground, finding common things Try to understand the person Trying to be objective Finding a balanced view Managing expectations Giving prognosis Good rapport essential Need to feel comfortable Personal connection Don't feel like a number Getting to know = two-way Communication – ongoing dynamic Building individual relationships Explaining approach to patient Exchange (relationship dynamics) Ongoing relationship (years) Discuss things NOT order/ instruction Confidentiality Feeling part of their pain An osteopath gets you to your body Feeling like you matter Getting reassurance Softer approach to advice (not order) Meeting patient halfway</p>	<p>Osteopathy Science Art Philosophy Not defined by one field or agenda Getting the complete picture. Broader long-term view. See people in all their realms Holistic picture Depth to Osteopathy See uniqueness of each patient Understanding patients in their entirety</p>	<p>Person in pain Complexity of pain – bigger picture Experience of pain (domains) People tell you what's wrong (non-verbal clues) Experience more important than the fee Satisfied with outcome Feeling like it is going to help An area troubling the patient</p>	<p>Mind/Body Therapy – powerful intervention Counselling – talking therapy Therapeutic encounter (talking and hands-on) Importance of healing touch Physical approach – power of touch</p>	<p>Need to listen to help you Knowing how to listen Listening and understanding (patient's experience of pain) Getting to the meaning of what the patient says Extracting relevant information – not just listening Dynamic – hearing and listening We let patients tell us "all" that's wrong with them Role as confidante Never giving back – listen but not advise Osteopath in counsellor role Not there to give advice Knowing when pts want to talk – making judgements Committed and interested JUDGEMENT CAL I</p>	<p>Public lack of awareness of Ost</p>
	<p>Looking to each other for answers NEGOTIATION Instigate the dialogue Two-way process/conversation Dialogue FACILITATION Partnership/TEAMWORK Good communication Shared responsibility Creation of strategies (more than just hands-on) Need to be able to engage with people (make a connection) Growing together (deeper involvement over time) RECIPROCITY Understanding why patient has pain Drawing it out of the patient Being seen about specific area Impact of silence</p>	<p>Dedicated space Welcoming environment Safe space (relationship/rapport) Attire has an effect Opening up a space to talk and share things. Appearance important – representative of therapy Positive environment Intimate setting Caring about personal presentation Instant impression - visual</p>	<p>Osteopath as a 'whole person' (previous experience) Patient perception of osteopath Appearing confident to the patient Rounded practitioners – bigger skill-set Position of osteopath – where they are in their life Keeping ego out of it How you portray self Personal recommendation Experience/qualifications – authenticity and pride Acceptance of professional</p>	<p>Leave patients with a LEGACY Feedback from patients Open door – continued communication Looking at client for feedback during consultation</p>	<p>Duty of care to patients Support in and out of treatment room</p>
	<p>Patient participation and input Helping pts to manage their own situation What you expect patients to do for themselves Giving advice to help pts to help themselves Pts valuing own health Promoting self-care strategies, altering reliance, locus of control Important for patients to educate self Patient needs to have responsibility for own health Get patient involved in own process Working together Patients looking after themselves Patients invest more in Ost consult (self-aware, body aware) Working together to achieve same goal</p>	<p><b>PATIENTS' HEALTH SERVICE</b></p>		<p>Boundaries fluid Separation between personal/professional roles Perception of casual/professional Boundary between friend/client Need to know where to draw the line – probing questions Caution in giving opinions Remembering own limitations Understanding self Limitations of area of expertise Some fixed boundaries/some difficult to define</p>	<p>Patients put their health in our hands Recognise things 'under medical radar' How to do the best for your patient Role as point of contact – referring on Steering pts Give pts back the power Turn pts into experts</p>
		<p>Making a difference to a patient Expectations for what can be achieved from the outset Having an effect on the patient Spreading knowledge (advocacy) Osteopath wanting to get patient out of pain</p>	<p>Know patients well enough to see contributing factors Looking at patient perception of pain/situation Ost interested in patient condition – not just MSS Locating surrounding issues. Raising concerns Focal, in-depth Understand what patient brings to table</p>	<p>Time for patients to express themselves and reach understanding Time to relax and talk, open up Time to build up trust Increased time makes relationships better Time to get to know the patient Luxury of time THE TIME BELONGS TO THE PATIENT &amp; NEGOTIATED Lack of rush Time to build relationship</p>	<p>Hands-on touch 40%/Relationship 60% You see people at their most vulnerable Hands-on – intimate/lack of distance/underwear Personal nature -</p>
		<p>Language and terminology Questioning skills Language (patronising/colloquial) Checking understanding Use of terminology Choosing words carefully Adapting language to suit understanding Perception of communication can vary</p>	<p>Lack of scrutiny Not having to stick to guidelines Not following set rule – freedom of TTT Lack of constraints (budget/protocols/time) Lack of prescriptive approach</p>	<p>Patients need to understand what is wrong and why Education – models/charts Educating patient – making patient aware n.b. GUIDED Educational process going on Knowledge – prevention and cure Educating patient – Educating Public Health Following instructions to reach goal KINDER APPROACH Wanting advice/education SUGGESTION rather than order</p>	<p>Shifting hierarchy – osteopath knowledge/patient has answers Individuality of patient Working balance – shifting identities</p>
<p>Not having all the answers – humility – admitting it – honesty Understand patients/situation – humility Being humble – it is about the patient</p>	<p>Evaluating progress – instant response Actively directly making a difference in peoples' lives Osteopath wants to help there/then</p>		<p>Keeping up to date Keeping <i>socially</i> up to date Being open to changes Communicating with colleagues Continuing to learn and be open Passing down knowledge Reflective practice Learning something new every day Evolving as a practitioner Development of the profession</p>	<p>Ability to read people (experience) Intuition and experience Intuition – adapting to treat pts individually</p>	<p>Continuity of practitioner – develop confidence and preferable to care Regular attendance – build up relationship</p>
				<p>Patients need to get help in the NHS</p>	<p>Allowing patients to do their own journey, develop own way Help the patient to answer their own questions</p>
					<p>Osteopaths learn from patients</p>

Figure 3 Initial key thematic areas

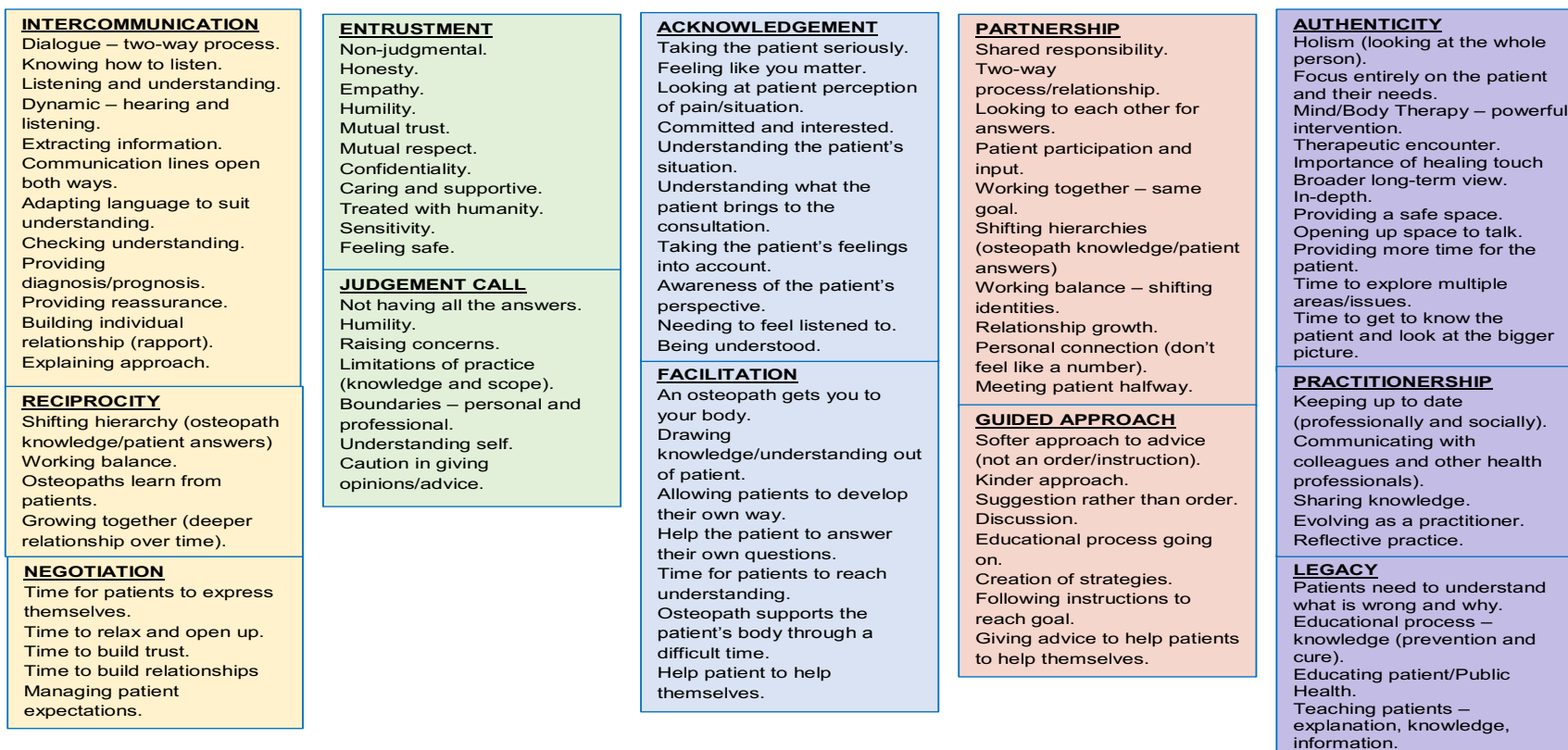


Figure 4 Twelve early key themed areas

During the data gathering process a methodological review was undertaken as it was an appropriate point to reflect on the methodology and tools as the data gathering progressed. This enabled a process of reflection 'in action' on the suitability of the methodology and utilisation of the vignettes whilst the research was progressing, how effective the process was, and the likelihood of adaptation or incorporation of further tools. It enabled me also to explore the use of 'gerunds', a tool advocated by Charmaz (2015) where the noun form of the verb is used to enable the researcher to locate the processes and meanings behind phrases and actions. This enabled me to direct my analysis more fully into the understanding of the process of professionalism in action.

No further examination of the literature was undertaken during the data collection process in line with the requirements for Grounded Theory. However, the findings from the Pilot Study, knowledge from my own experience in the field and philosophical perspectives were included into the interviewing and focus groups while maintaining my own reflective process using memos and a research journal.

The data collection process for the main study spanned nine months in which 29 interviews and seven focus groups were undertaken. This resulted in a large quantity of data which were continually analysed, coded, developed into themes, and mindmaps created to visualise the growing data into the construction of a theory. The four research questions were continually referred to:

1. How do the beliefs and values of osteopaths, students and patients form their individual concept of osteopathic professionalism?
2. Is there a consensus of osteopathic professionalism amongst all stakeholders in the osteopathic remit?
3. How does an osteopathic theory of professionalism compare with those of other healthcare modalities?
4. How can the theory of professionalism be taught to student osteopaths?

The initial pilot study, followed by the iterative process of analysing the data in the main study, gathered a large quantity of rich information about stakeholders' perceptions of professionalism and their experiences of this in osteopathy. The

iterative process of exploring individual perceptions through one-to-one interviews, then using the constant comparative process through focus groups to explore the data and test the growing understanding on individual groups was developed through six focus group iterations to a final mixed stakeholder focus group. How it informed the research journey and the development of an understanding of professionalism in osteopathy is discussed in Chapter 5.



## **Chapter 5 Findings**

This research set out to explore a theory of professionalism in osteopathy by seeking the perceptions of osteopaths, students and patients. This was undertaken in a pilot study by exploring the strength of opinion of these stakeholders as to which values and attitudes were deemed important and to what degree. This provided a basic understanding of the 'flavour' of professionalism in osteopathy on which the main study could then be undertaken.

### **Pilot study findings**

As there appears to have been no research into the remit of professionalism in osteopathy, the initial Pilot Study was designed to explore values and attitudes important to stakeholders in this field. The online questionnaire used Likert scales for their effectiveness in capturing the strength of participants' opinions on values and attitudes (Johns, 2010). The avoidance of a 'middle ground' option which might afford participants an option to avoid either a positive or negative response avoided regression to the mean. Participants were also asked to add values or attitudes they felt were pertinent to osteopathy. Thirty-one responses were returned: 9 osteopaths, 9 students and 13 patients. Two students and one osteopath completed the responses for the values but did not provide responses for the attitudes however the reason for this is unknown.

The responses were adapted into numerical figures and compared using the Kruskal-Wallis test (Cohen et al., 2007) to explore whether there were significant differences between the perceptions of the three groups. Thirty-one respondents completed the first section on values, 28 respondents completed responses for attitudes.

The responses to the survey showed statistical significance using the Kruskal-Wallis test in 6 areas (Appendix 13, p.220), only two of which achieved true statistical significance on further testing:

### **Compassion**

Title	Number	Mean Rank
Osteopath	8	16.56 <sup>ab</sup>
Student Osteopath	8	10.17 <sup>a</sup>
Osteopathic Patient	13	19.65 <sup>b</sup>

### **Working to the Osteopathic Practice Standards**

Title	Number	Mean Rank
Osteopath	8	15.56 <sup>ab</sup>
Student Osteopath	8	8.94 <sup>a</sup>
Osteopathic Patient	13	21.19 <sup>b</sup>

*(N.B. a and b indicate where mean scores flagged with the same letter are not significantly different from each other, whereas mean scores flagged with different letters appear significantly different from each other).*

These showed statistically different results between students and patients, with students rating these values significantly lower. It is interesting to note that students ratings were lower than osteopaths or patients for 14 of the 17 values yet this did not follow a pattern with their responses to the attitudes, so it is possible that they had difficulty in evaluating and conceptualising the values. The statistically significant responses did not match the associated attitudes or values therefore these do not form reliable indicators. The internal consistency for each of these collective groups was high and is shown in Appendix 14 (p.222).

The survey asked participants to provide values that had not been included but which they felt were important in osteopathy. Five responses were offered by more than two participants. One of these, “being non-judgemental”, was deemed to already be present within the values and attitudes (integrity and respect) but present using alternative terminology. The four remaining suggestions did not appear to be included in the values within the questionnaire: being reflective, empathy, humility and advocacy.

This study was conducted on a very small scale with unequal numbers in groups which may have affected the findings. The two smaller groups,

containing osteopaths and students, also lost data by three participants not completing the survey on attitudes and the reasons for this are not clear. These findings do not give a definitive picture of the values and attitudes perceived within osteopathy and also do not provide a clear picture of how each stakeholder group distinguishes the importance of these constructs. It does provide an indication that the values are not easily understood as abstract concepts, largely as the students' ratings were repeatedly lower than those of osteopaths and patients. This indicates that educationally this may not be an appropriate tool to use in order to teach these facets of professionalism and that the strength of the attitudes helps to 'paint the picture' in order to aid conceptualisation. This was important to me in formulating the use of vignettes which would enable participants to explore deeply held values and attitudes more fully and within practice context scenarios. By exploring students' understanding more deeply and engaging students in discussion linked to practice I hoped that they would be able to discuss these more fully in order to capture their perceptions in greater detail.

The findings also concur with the literature, that there is little agreement amongst different stakeholder groups as described by Rassin (2008). It also indicates that there is perceived difficulty in conceptualising and agreeing on the terminology for the professional attributes (whether values or attitudes) and this links strongly to the professional literature discussed earlier (Krain and Lavelle, 2009) and that the language and terminology used are critical in formulating a collective understanding of exactly what each value or attitude means to each stakeholder. This was indicated within Chapter 2 with Sehiralti's (2010) appeal that the language should be suitable for incorporating into the educational system and Wagner's (2007) assertion that it should be understood by patients.

The Pilot Study also showed that the strength to which participants agreed or disagreed with the concepts varied between stakeholder groups and this indicates that the values patients believe are important are not always equally shared by osteopaths or students. The implications of this are pertinent in all aspects of osteopathic care, from managing patient expectations, to sharing the responsibility of care. The onus of providing best practice cannot be achieved if participants in the professional relationship are not aligned (Rassin, 2008).

### Main study findings

The main study was designed to build on the initial pilot study by exploring in depth the perception of professionalism of osteopaths, students and patients. It was initiated in February 2017 using Grounded Theory methodology. In total 29 participants were interviewed, followed by seven focus groups: three individual stakeholder facilitated focus groups; three individual stakeholder unfacilitated focus groups; and a final mixed stakeholder focus group. The data were collected iteratively throughout these stages and developed using coding, followed by the elaboration of themes in the process of developing a final theory of professionalism in osteopathy.

The first stage of the main study involved one-to-one interviews with osteopaths, students and patients. After a day's interviewing I transcribed the data and started to code it. During the early stages of analysis I was surprised by certain comments or particular nuances of understanding that emerged from various participants, across the range of stakeholders. These required me to self-reflect, not only on the data I was collecting and whether my emotions might have an effect on the codes I ascribed, but also on my own osteopathic practice. These moments of surprise were sometimes positive in nature, but occasionally were divergent with my own professional perspective, in which case I made a note in my journal to ensure that I could reflect and refer back to it.

### Researcher surprise

Some participants' responses surprised me in their level of understanding or in their approach and I acknowledged a range of emotions from realising that I had not been aware of perceptions, through surprise at participants opinions to feeling impressed at some participants' level of knowledge or awareness. One patient talked of her presumption that an osteopath always knew what to do and had answers to hand:

*...as a patient you never consider what's going through the osteopath's mind. You assume that they know what they're doing and that it just flows. So, I suppose that's the selfishness of the patient in a way, that*

*you're considering your needs but you're not thinking necessarily about what's going through the osteopath's mind and how they're sort of processing what they can do to deal with you as a person. Quite interesting.*

(Maureen, patient, interview 31/3/17).

I had not considered this before and my prior perception had been that patients were aware of the exploratory diagnostic process and formulation of options for decision making.

Osteopaths' perceptions of practice were sometimes different from my own and I was surprised by some descriptions of their approach:

*Sometimes they come in, you know, a new patient or relatively new, sometimes they can be a bit nervous of treatment or a little bit guarded anyway, because some people are until they get to know you, and then you get them prone and relaxed and then they respond a bit better.*

(Timothy, osteopath, interview 16/2/17).

This is not an approach I would have taken, as in practice I feel that eye contact is important and placing patients prone (on their front on the couch), while possibly being a comfortable position for some, limits the ability to build rapport by taking away a key major connection. However, it is equally true that forcing eye contact on some people might make them more nervous. This encounter made me reflect that there are many approaches and made me increasingly aware of reflecting not only on the research process but on my own practice.

I was pleasantly surprised by students' depth of understanding of the concepts surrounding professionalism as they showed immense reflective ability:

*...we do critical reflections here and something has triggered off within yourself - ... feelings and emotions - is to understand what that has represented to you. Within those dynamics with those certain patients. So, yeah, there's - there's an awful lot of work still to be done, but*

*personal growth is kind of the best thing that you can probably give your patients really.*

(Keith, student, interview 19/2/17).

Many students appeared to show strength in understanding the holistic nature of the interaction, in the sense of considering all aspects of a patient's physical and psychological presentation. Holism is defined as the consideration of the whole person, taking account of psychological and social factors as well as medical factors in considering their wellbeing (Oxford Dictionary, 2018). Students evidenced the ability to reflect on various patient interactions throughout the interviews thereby demonstrating a good ability to learn from experience.

#### The hidden data

Only eight participants mentioned 'touch' during the interviews and as I was analysing the data it seemed to be important by its omission. I wondered why participants had not discussed it when it is such an intrinsic part of the osteopathic consultation, since we use our hands to examine and treat and it is a facet of our practice which is increasingly so different from other healthcare specialties where a hands-on approach is less used. I wondered whether it was there but just hidden? This, then, became one focus of further exploration within the focus group stage of the research as it appeared to be a facet of the osteopathic consultation that was possibly taken for granted by all stakeholders – something that was fully expected but not rationally explored:

*They're expecting us to touch them because sometimes that's their main complaint is that somebody hasn't touched them and hasn't found out what's wrong with them and we do.*

(Sarah, osteopath, focus group 21/5/17).

In comparison, 18 participants talked about trust and the importance of this, yet it appeared to be poorly explained and rationalised:

*...it's an innate thing I think that you actually trust .....by the time you come to the osteopath as an adult you've got all these tools that you've*

*been given throughout your life - you've been given those tools and I think it's just, it's just a feeling you know.*

(Aileen, patient, interview 29/1/17).

*I guess it's something that they must do initially and they trust you and they build up, and it's like, yes, I don't know - they just trust you really. So, and it's not something that you can explain, or, do. Some people trust you, some people don't really.*

(Keith, student, interview 19/2/17).

This was an interesting initial focus which then required further exploration to uncover how participants experience and develop trust in the osteopathic remit.

After the 29 interviews were complete, I uncovered five key themed areas which contained facets that participants felt were important to professionalism in osteopathy. These were collated into themed collections where the facets intrinsically related to each other, either directly or organically in the sense of how they were discussed as integral to one another within osteopathic practice. This raw collection of data was developed into a mindmap (Figure 5, p.75).

This was undertaken to aid a visual representation of developed concepts which I felt helped in my understanding of what was evolving through the research. These themes informed the focus group discussions in developing a greater understanding towards the production of a theory. After the seven focus groups had been undertaken and as no new data were emerging, the developed themes gave rise to the final theory: the PIECE theory of professional trust in osteopathy.

### The PIECE Theory of Professional Trust in Osteopathy

The aim of the main study was to explore perceptions as to what constitutes professionalism in osteopathy from osteopaths, students and patients as this was an area that did not seem to have been researched before. Through 29 interviews and 7 focus groups, data were collected from participants in stages using the constant comparative process to explore and confirm themes that were emerging. The theory that has developed from the interviews and

subsequent focus groups is discussed in five key sections and analysed in relation to the existing literature on professionalism in healthcare with particular reference to the elements of dialogue and touch. The voices of the participants will be used to illustrate the theory, and the depth of consensus on particular areas will be shown by including a number of participants' opinions on key themes. The strength of using participants' voices in the presentation of research appears integral to social constructionist research and showing how the theory has been co-constructed (Charmaz, 2008a).

The iterations of data collection, from individual interviews through facilitated and unfacilitated focus groups with individual stakeholder groups, through to a final mixed stakeholder focus group has accumulated a vast range of stakeholder views and experiences. Each data collection interaction has allowed me to further explore particular key areas, for example a general overview in the original one-to-one interviews using the video vignettes; questions probing experience of touch in the facilitated focus groups; questions asking for experiences of professionalism in practice in the unfacilitated focus groups and finally further exploration of touch and what osteopathic professionalism looks like in practice in the final mixed focus group. This probing along lines of enquiry has grown out of the findings at each stage and has resulted in the birth of new questions for each iteration of the research.

The concept diagrams, flowchart and development of the final theory progressed and grew throughout the main study from the data collected from participants. Key words and phrases, the strength of agreement of participants on particular themes, the frequency and repetition of concepts, ideas and experiences from all stakeholders aided in the development of the final theory: the PIECE theory of professional trust in osteopathy which can be seen at Figure 6 on page 76.



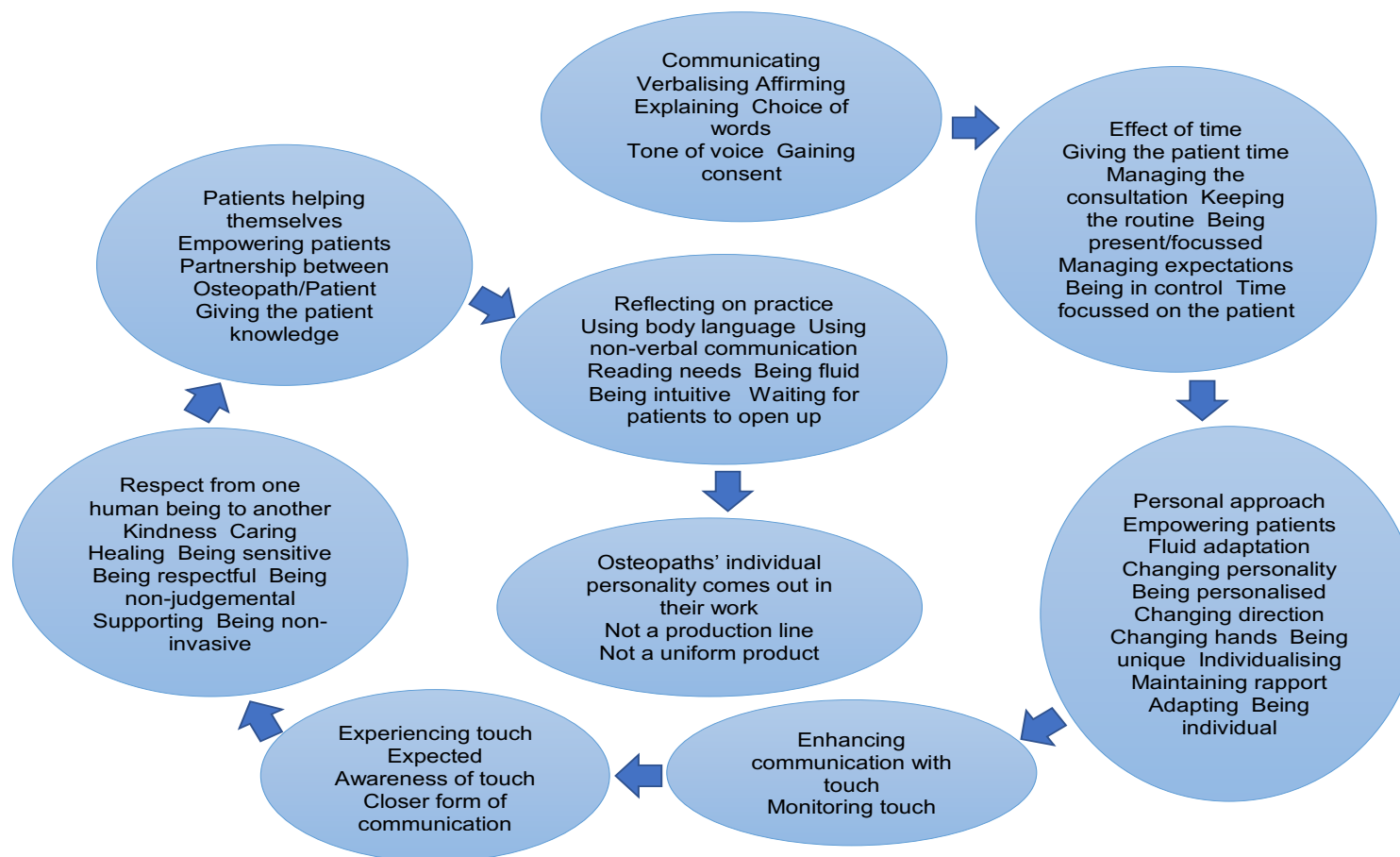


Figure 5 Mindmap of developing themes

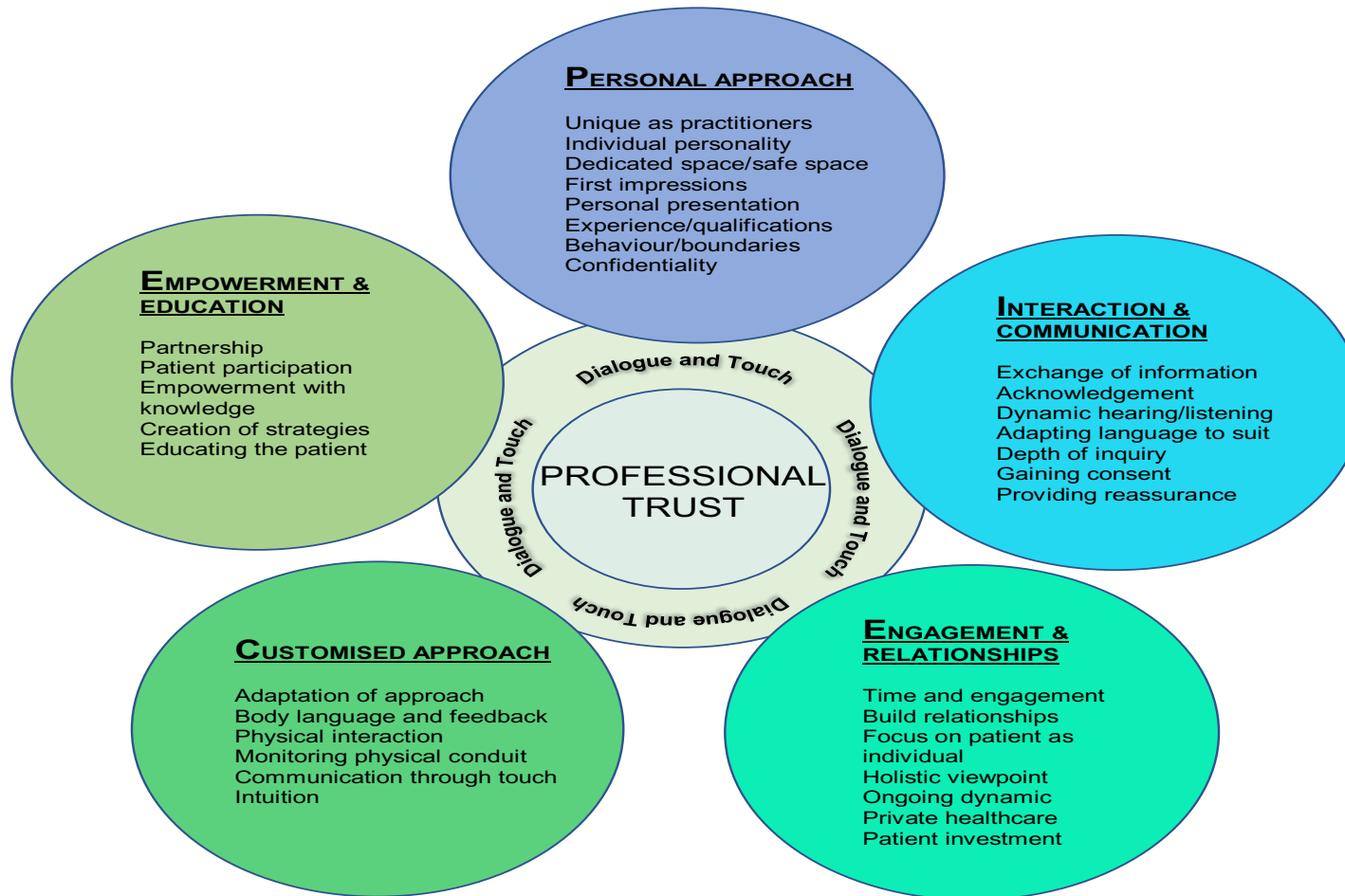


Figure 6 The PIECE theory of professional trust in osteopathy

## Professional Trust

The final 'theory' has not been a theory of 'professionalism' but more an understanding of osteopathic professional trust. This emerged very late in the process when the repeated weight of 'trust' discussed by patients became too overt to ignore. The data collection process had shown how trust is developed, built and enhanced through the relationships which are developed between osteopaths and patients in the course of repeated osteopathic consultations, but did not allow for the first consultation where participants are unknown to one another and a relationship is yet to be built. This concept of 'blind faith' or 'blind trust' at this stage kept emerging and from the data emerged this concept of professional trust whereby patients 'trust' that the osteopath will do the right thing by them professionally:

*I think it comes back to the trust in the profession that you just assume that, you know, they know what they're doing and they know how to deal with whatever problem they're presented with ..... it's a magic word, trust.*

(Maureen, patient, interview 31/3/17)

This initial trust is not just seen as a 'leap of faith' but gauged from first impressions at the initial consultation:

*It's in the eyes, it's in how they speak, it's in their whole body, it's in their demeanour, so you know if you can trust somebody.*

(Aileen, patient, interview 29/1/17)

This initial trust is discussed by Lee-Treweek (2002) as an initial construction of rapport between the osteopath and the patient developed through character traits. However, this was also discussed in my research as something that built through time, relationship and depth of experience:

*I think that's something that comes with time ..... It's a build-up of trust and comfortable - of being comfortable with a person. That*

*you feel yes, they have your best interest at heart. And that's what really matters.*

(Cara, patient, interview 3/4/17)

*.... if you go regularly you build up that relationship and that partnership. You know, you hopefully see yourself improving and things as well. But yeah - it's time and trust.*

(Scarlet, patient, interview 8/3/17)

This trust appears to have different facets: an initial 'unknown' trust where patients appear to have faith in the osteopath's professional actions and this appears to be followed by a developing trust through engagement and a growing relationship:

*They get to trust you - there's a mutual trust, mutual respect, communication lines are open both ways.*

(Sarah, osteopath, interview 7/2/17)

This trust is dependent on exposure to the osteopath, a developing understanding of what the osteopath can offer and a building connection and rapport with the osteopathic practitioner. These findings align with other research where trust is seen as an evolving process as stated by Scarlet above. Ehsan and Ashill (2014) highlight this as particularly important while Krot and Rudawska (2016) discuss how it is important to preserve time to allow this to develop. As Scarlet states, time is key in providing the space to build a productive relationship and this is discussed by Fiscella et al. (2004) who state that the time given to this part of the relationship is frequently key in building trust. They claim that levels of trust appear to be increased and maintained through the construction of long-term therapeutic relationships. Ehsan and Ashill (2014) claim these are not static but changeable over time allowing practitioners to develop long-term relationships which increasingly reduce levels of uncertainty. As Sarah, an osteopath, commented above, this is built and achieved through effective communication and not only improves the interaction between the patient and practitioner, but as Van den Bruink-Muinen and Rijken (2006) describe, can be important for patients' quality of life in the sense of

developing a supporting relationship. Goudge and Gilson (2005) also describe how trusting relationships between practitioner and patient can lead to potentially better treatment outcomes due to increased compliance and cooperation with advice and self-care. This contrasts with the initial 'blind trust' described by Mechanic and Meyer (2000) which appears to be an acceptance of the role and perceived standard of the practitioner by the patient.

What appears to be particularly important in the research is the contextual nature of the formation of trust (Douglass and Calnan, 2016) where the situational workplace environment influences the attitudes and behaviours of practitioners. They describe this as working in two ways – both trust of the practitioner but also trust from the practitioner of the patient in the sense of the patient providing honest information to enable treatment. Piippo and Aaltonen (2008) describe trust as the building of mutual understanding which requires a two-way interface in order for it to be built. This is important in my exploration of trust in osteopathic practice in understanding how the situational nature of osteopathic practice, in its many forms, can mediate how this occurs. It appears that the dialogue and building of a partnership is imperative in developing this in the osteopathic remit.

The issue of patient vulnerability also appears important in the literature surrounding trust in healthcare whereby patients present with illness or dysfunction (Calnan and Rowe, 2006), provide detailed personal information and where a strong emotional component is attached (Goudge and Gilson, 2005). Again, this is relevant to trust within the osteopathic encounter where patients are required to divulge personal information, both medical and psychosocial, undress to their underwear and are treated by osteopaths with a hands-on approach. Not only this, but patients frequently present to healthcare practitioners with chronic health conditions. This potentially increases their level of dependence on or expectations of the practitioner, and the level of care appears to be as important as the outcome of the consultation (Van den Brink-Muinen and Rijken, 2006). This is extremely pertinent to the osteopathic remit where patients attend and require ongoing treatment, sometimes for protracted periods of time. The development of the relationship, and creation of a partnership is therefore potent and vital. In particular, the development of a

good level of trust has been shown to be linked to health benefits, as shown by Fiscella et al. (2004) and the maintenance of this is essential to providing continued good care.

Within the PIECE theory of professional trust in osteopathy five key themes have emerged:

- Personal approach
- Interaction and communication
- Engagement and relationships
- Customised approach
- Empowerment and education

These encapsulate facets of osteopathic professionalism, all of which are bound together by the concepts and entities of dialogue and touch. These two factors have emerged as critical components within the osteopathic arena. The concept of dialogue and the importance of touch have been recognised by all stakeholders and are pertinent in every area of the interaction. I will briefly explore their importance to the theory and how they emerged in the research before discussing them in relation to the five themes afterwards.

#### The importance of dialogue

The focus on dialogue as a part of communication emerged strongly from the data. Communication, itself, appears to be an essential component of the professional osteopathic interaction and is part of one of the themes of the theory, but it is the nuanced presentation of 'dialogue' which has proved to be a key facet which pervades all areas. 'Dialogue' is characterised in the data as a two-way conversation between osteopaths and patients, which is marked by a freedom of speech and expression and where questions are encouraged. Participants spoke about effective prompting to gain necessary information and creating an effective two-way connection between practitioner and patient. For example Jill (patient, interview 4/4/17) emphasised that dialogue is "what you do in life" and Sarah (osteopath, interview 7/2/17) agreed saying:

*...they come in on a day and you think 'what am I going to do today? What am I going to do to help them?' and sometimes I've realised that it's the*

*dialogue that's the important thing - talking about it - the creation of strategies to deal with things is sometimes more important than the actual hands-on stuff we do, you know?*

(Sarah, osteopath, interview 7/2/17)

Dialogue has been seen to be important as a means for providing effective communication (Taylor, 2009). Patient-centred communication is the direction for healthcare in the twenty-first century where patients are active participants in their health journey and encouraged to mutually take responsibility, collaborate and make decisions. This has been seen to be more popular with patients who have more extensive educational backgrounds and higher-level occupations and it therefore requires practitioners to evidence flexibility and an adaptable approach to patients (Saha and Beach, 2011). This change from a paternalistic approach to including patients in the decision-making process fits well with the osteopathic principles of taking a holistic approach and incorporating biopsychosocial components into the consultation. This has been evidenced through my research whereby osteopaths verbally presenting themselves to a patient, creating and maintaining partnerships, and educating patients to be more greatly aware of their own health and wellbeing has proved to be valued by patients, which will be shown later in themes within this theory.

Communication skills are taught within osteopathic educational programmes, both in the classroom and developed in the teaching clinic. The importance of this specific form of communication, a dialogue between practitioner and patient, is interesting for a number of reasons. Firstly, the push for patient-centred care (Schubert et al., 2008) within all spheres of healthcare demands greater input and decision making from the patient. Secondly, healthcare is becoming more consumer driven and therefore the communication strategies of healthcare practitioners require to be more nuanced and personal to each individual patient. The dialogue discussed by all stakeholders in my research emphasises these points. Students within osteopathic educational colleges should be enabled to develop and practice their dialogic skill in order to engage with patients more proficiently, to create patient-centred care and ensure that the therapeutic relationship is functioning optimally. This may require more nuanced teaching and learning strategies to ensure that students acquire these skills and suggestions for this will be developed in the next chapter.

### The importance of touch

The focus on touch in the osteopathic consultation is key as, on a clinical level, it is the means by which osteopaths examine patients in order to be able to treat and provide relief from pain or physical dysfunction. Through changes to ethics, issues of informed consent and patient rights, touch increasingly requires thought and clear intent in process and outcomes:

*..... it's not a common practice, um, in the medical profession to actually have hands-on the patient very often these days. And particularly in the allopathic world where you are more, almost distanced, I think ..... but we spend almost all of our time with that contact on our patients.*

(James, osteopath, interview 24/2/17)

The power that touch can convey is very much at the forefront of the osteopathic interaction and is the major tool that osteopaths utilise in order to examine and treat patients. The use of touch in conjunction with dialogue is therefore seen as a powerful tool:

*But I also think that being able to do that [talk] in conjunction with touching their body and moving the parts that hurt, creates a really powerful intervention that, just talking, or just pressing on things separately, I don't think achieves in the same way.*

(Clara, osteopath, interview 7/2/17)

The impact of touch was also strongly evident from the patient viewpoint and they expressed awareness of the power of touch, particularly where patients might not have had physical contact with another human being for some time. It was seen as comforting and a powerful connection between patient and osteopath. However, the potential vulnerability of the patient to the osteopath's touch requires that the osteopath is professionally responsible and careful in their approach. The patient requires clear communication and reassurance in order to trust the osteopath and it is partly in this way that both trust and touch are inextricably entwined. Touch has been seen to have many constituents and is used as a technical tool for examination and diagnosis (Bjorbækmo and



Mengshoel, 2016), while Consedine et al. (2016) describe how it can promote engagement and provide support and reassurance. As such, it is a powerful means of communication (Routasalo, 1999) that Elkiss and Jerome (2012) suggest turns the stimulus of touch into subjective awareness and interactive responses and is not one-way – the practitioner and patient both feel the reciprocal touch. As Clara commented above, touch and verbal interaction together appear to reinforce one another, and Gallace and Spence (2010) describe how touch is perceived as stimulating a more powerful emotional response than communication (verbal) alone and most importantly does not occur in isolation – it is inevitably entwined with verbal communication or visual clues. The effects of touch, much like the concept of professionalism, are difficult to define. The scientific basis and neurological processes of touch have been discussed (Serino and Haggard, 2010) but *how* touch is perceived and received by patients is still unclear (Routasalo, 1999). Touch is taught within osteopathic educational curricula in technique classes and through developmental stages within the teaching clinic. However, this is often technically taught from the practitioner's perspective with a focus on a therapeutic outcome without clear consideration for the emotional or psychological impact on the patient. These are considered in other areas of the curricula where patient cases are discussed, critical incidents are reflected on and a portfolio of student development is collated and reflected upon. These useful educational tools are undertaken in isolation and there does not appear to be a clear thread running through curricula to bind these. The knowledge gained from this research indicates that touch is a binding influence within all areas of the osteopathic consultation and therefore students and qualified practitioners need to be critically aware of how touch impacts the process and learn to reflect on and develop their palpatory skills to enhance the interaction. Educational curricula need to prepare students more effectively for the potential effects that touch can stimulate alongside the clinical aspects of osteopathic clinical touch. This will need to encompass a greater awareness of the emotional elements of touch, the element of building trust through touch and developing increased awareness of patients' reception to touch and verbal and non-verbal feedback. Suggestions for educational tools will be made in the next section.

These facets of trust, dialogue and touch will be explored throughout all areas of the theory.

### Personal Approach

The first theme of the PIECE theory of professional trust in osteopathy concerns the personal approach which denotes each osteopath's individuality as a practitioner, but beyond this 'difference' of individuality there appears to be a more 'bespoke' uniqueness:

*I think that's what's so important because what you bring to the work as a person, influences the way you work. So, it's about - it's not just about treating the whole person - it's about you being a whole person too, and we're all unique, and we all have different experiences.*

(Anna, student, interview 14/2/17)

This is important, as osteopathy is a 'holistic' therapy, in the sense that it considers the patient in their entirety (mind, body and spirit) and does not focus merely on one area of the body or aspect of health. An osteopath will consider the patient's entire posture, their physical health (considering all bodily systems) alongside their mental and emotional wellbeing when deliberating examination and treatment. But the osteopathic encounter does not just consider each patient as an individual, the osteopathic practitioner is allowed to be individual in their own way too:

*An osteopath is an osteopath is an osteopath, you know? ..... You know, Hope\* is an osteopath - but she uses bioenergetic cranial therapy that I wouldn't even have the first idea to approach. We're all osteopaths, you know. What we have is a toolkit and I pick out of that toolkit the right tool for the right patient.*

(James, osteopath, interview 24/2/17) \* pseudonym

This uniqueness as a practitioner was recognised by all stakeholders who discussed the individuality of the practitioner and how it is important in providing a wide spectrum of treatment options and enabling connections between osteopaths and patients to be more personal and unique and this was evident

in discussion with the osteopaths in this research and expresses a difference from the calls for a collective identity by Jotterand (2005) as discussed in the debate on the definition of professionalism in Chapter 2 (p.16). The difference between how osteopaths present themselves was not seen as problematic by patients, they merely stated that they wanted the osteopath to appear confident in their approach. However, osteopaths and students were aware of their varying approaches and showed an appreciation of the need to clearly define their style of practice, and what they can offer to each patient. In osteopathy there is a spectrum of practice with some osteopaths practising in a very biomechanical, structural way using spinal manipulations and direct techniques to address musculoskeletal dysfunction. The spectrum also encompasses osteopaths who use quite gentle 'visceral' techniques and those who practice cranial osteopathy which uses very subtle techniques using miniscule movements. This has implications for the different forms of touch that osteopaths use in practice and it therefore requires a clear dialogue with patients to ensure they are aware of what an osteopath can offer and what a patient can expect from a consultation. Students commented on how they appreciated the variation within practice and the benefit of treatment choice they were able to give patients. Osteopaths discussed how practitioners' personalities were enabled to emerge through their work via their style of practice. It appears that not only do osteopaths need to be clear about their style and approach within osteopathy, they also need to project their individuality and personal approach too:

*You want to be professional. You want to do your patients good - you want them to come out feeling that it's worked. I suppose, in that way we're all approaching it from the same ..... But then everybody's personality, how you would respond to patients - that's got to vary.*  
(Flora, osteopath focus group 21/4/17)

Osteopaths seemed to value their unique differences and approaches and Sarah, an osteopath, described how osteopaths did not want to appear to have come off a production line, or all be the same. Clara, another osteopath, commented that students are taught to be osteopaths but not as uniform products. The distinct nature of the practitioner, each an individual, appears to

be highly valued by osteopaths and students, and equally accepted by patients. Patients discussed seeking relief from pain or an explanation for it, but did not seem to mind the approach taken, their concern was more in receiving a satisfactory outcome. In other healthcare spheres there may not be such a wide variation in styles if the practice remit does not contain so many diverse approaches. Osteopathy does not appear to be a 'conformist' profession as in my research there is very much the sense that the individuality of the practitioner is important to osteopaths and is something to be appreciated, encouraged and endorsed.

The personal presentation of the practitioner appears important to patients in this research in the sense that it is part of the initial appraisal between osteopath and patient and an early part of the development of trust and this concurs with Lee-Treweek's (2002) findings that personal presentation is important to the emerging relationship. First impressions seem to matter hugely, particularly regarding building confidence and trust so that patients feel able to proceed with the consultation and engage with the osteopath:

*I would come in and possibly be scanning the room. I tend to scan anyway. But I, yeah, for me personally, the whole, the whole picture is everything. It's voice, body language, cleanliness, you know, what you're laying on and, and also whether you're helping as well with the pain and so it's the whole, it really is the whole picture for me.*

(Aileen, patient, interview 29/1/17)

*And that initial contact is key, isn't it? When you open your door and meet that person - eye contact first. We're suddenly assessing each other, we're sizing each other up in a way, aren't we?*

(Sarah, osteopath, final focus group 25/11/17)

Attire and first impressions of behaviour appeared important although there appeared to be no consensus as to what form of dress should be worn and Wayne, a student, commented that he and his peers had discussed dress code and reached no consensus. He commented that they had come to the conclusion that a professional presentation was important whatever the

environment and a style of dress that could instil confidence in a patient. Patients in this research did not state specific codes of dress for osteopaths, yet the consensus showed that they expected a clinical presentation as John describes:

*Yeah I think, I think it's important that you should be dressed in the right clobber. Look the part as well as be the part, you know?*  
(John, patient, interview 17/2/17)

This differs from research where a survey of doctors in a multinational study deemed appearance to be a non-essential attribute of professionalism (Chandratilake et al., 2012), whereas in another study appearance was considered to need to be adapted to cultural differences (Jha et al., 2006). Wiggins et al. (2006) have indicated that patients would like practitioners to present a good appearance but their listening and communication skills have greater importance. This is interesting as Van Mook et al. (2009) in the debate surrounding values, attitudes and behaviours, indicated that behaviours are not always dependable, so the personal attire of a practitioner may not necessarily indicate their values. It may be that how a practitioner interacts and communicates may provide a greater window on their values and attitudes as a relationship unfolds.

The discussion surrounding attire also focussed on the issue of boundaries and how this can be important as a barrier between the practitioner and the patient. This centred around attire as a protective mechanism, effectively providing a physical boundary between participants in the consultation:

*I wear surgical scrub tops in clinic, er, but that's just because I was working in a GP surgery and I think the environment that you work in does play a part in that ..... I think there is definitely an importance to that and it does protect the osteopath as well, I think, actually, if you are sat there looking like a clinical professional, you know, it does help to define that boundary certainly.*  
(James, osteopath, interview 24/2/17)

Osteopaths do not have a defined form of dress that is circumscribed and in practice there is quite a diversity of workwear. Some students discussed adapting attire to suit the locus of work, for example wearing smart sportswear if working within a sporting environment. There was no consensus on what was ideal or appropriate in general and patients did not appear to have any particular preference, but all participants agreed that a smart, clean presentation was important and that it should relate to the environment in which each practitioner worked, and this concurs with previous research that patients appreciate a neat appearance (Wiggins et al., 2009). It appears to be an element which contributes to the building of confidence in the practitioner which is a constituent element of building trust.

The presentation of the practice environment appears to be as important as the presentation of the practitioner, but there was no consensus on what it should look like beyond being clean, tidy and hygienic. However, many participants talked about the need to feel safe within the environment. The concept of a dedicated space or a 'safe space' was discussed by many participants as an important factor when first consulting with an osteopath. This was alluded to in reference to the need for patients to be assured of confidentiality and privacy:

*So the space is important - a safe space for people to be able to share things.....I don't think there's any um, rules you could set to say, I don't think you could put it in the OPS [Osteopathic Practice Standards] to say that 'if you do x, y and z that you will open up a safe space'.*  
(Paul, student, interview 16/2/17)

*I think there's that element of patient/practitioner relationship ..... it's a confidential space and it's actually - might be the only space they've got to talk to someone.*  
(Peter, osteopath, interview 6/4/17)

This is an interesting focus as the concept of a 'safe space' is not mentioned in either the previous or updated Osteopathic Practice Standards (General Osteopathic Council, 2018, 2012), neither does it appear in guidelines for other medical or healthcare regulatory authorities. The concepts of undertaking a

comprehensive case history and capturing sufficient information to provide safe and ethical care is mentioned but the environment, either physical or affective, in which this is undertaken is not specified and there does not appear to have been much focus on this in the healthcare remit. Whether this is linked to the increased time that osteopaths provide for the consultation, an awareness of the holistic approach which incorporates a patient's emotional wellbeing or a factor of the fee-paying nature of osteopathy is unclear, but it would be a beneficial line of research to pursue in the future to explore the nature of this 'safe space' in osteopathy and this will be discussed in Chapter 7. Covington (2005) describes a safe space in nursing as formed from a caring presence which empowers patients in decision making while Kisfalvi and Oliver (2015) describe a therapeutic relationship between practitioner and patient as the basis for the safe space. Within my research the concept of the 'safe space' appears to allude to an aspect of the interpersonal relationship between osteopath and patient rather than the physical environment. The safety aspect appears to be developed from a form of trust enabled through confidentiality and security which enables patients to feel able to impart information. This potentially opens up the arena for dialogue and requires verbal reassurance from the osteopath.

The confidentiality required for this 'safe space' is a part of professional responsibility that appeared to be a vital component of the interaction and an important part of the evolution of trust within the professional interaction:

*Based on my experience, yeah - I've seen some patients really open up about personal stuff, stuff they said they've never told anybody before ..... Especially to the patients who come back week after week, I noticed that, yeah, just being able to talk to practitioners is the main thing for them in confidence and with someone they trust.*

(Jo, student, interview 14/2/17)

*The trust. And the trust is the thing. When I come here to have my back done you tell people stuff about personal that you wouldn't tell just anybody. You know, you're sharing...*

(Patient, unfacilitated patient focus group 15/7/17)

Whether patients feel able to open up due to the rapport with the practitioner, their sense of safety within the environment or other components is not clear from this research. This can lead patients to divulge significant and in-depth information which is rich and informative for the osteopath in evaluating, diagnosing and structuring treatment plans. Whether this is linked to an effectively evolving relationship with the osteopath or the holistic approach of the interaction is unclear, but it is very much present, discussed by many stakeholders and greatly valued. Students described how they perceived patients to feel safe to 'unload', aware that the consultation was confidential and aware that patients should be given the time to express themselves. Patients talked about feeling able to open up in the osteopathic consultation and confident to share private information.

The importance of capturing private, and sometimes emotional, knowledge as opposed to securing relevant and sufficient clinical medical information was also apparent. The awareness of this was evidenced by a delineation between respect for private personal and emotional knowledge and what was deemed essential for the safety aspect of the clinical consultation. Students and osteopaths were aware of the responsibility for patient care, both clinical (osteopathic and medical), emotional, and in terms of welfare:

*... we have to make sure we have our questions answered. Because as I say, it's about the, the safety factor with patients who are in severe pain. You want to make sure they're safe to treat so you have to ask the questions and they have to understand that you have to ask the questions too.*

(Sarah, osteopath, interview 7/2/17)

The issue of gathering sufficient and appropriate information in order to provide safe care is evident in the Osteopathic Practice Standards (General Osteopathic Council, 2018, 2012) and appears in all major definitions of professionalism, for example Good Medical Practice for doctors in the United Kingdom (General Medical Council, 2013). The expectation of safe and competent practice with sufficient clinical skills appears to be a key criteria of a professional practitioner (Royal College of Physicians, 2005; American Board of



Internal Medicine, 2002) and this is a requirement of any osteopath, whether just qualified or an experienced practitioner. This is particularly important where patients can attend an osteopathic consultation without having seen their General Practitioner prior to the consultation, so it is imperative that osteopaths are able to screen and diagnose effectively to ensure that best care is provided and any necessary medical referrals are made. Osteopaths and students were well aware of this requirement and patients expected practitioners to be competent to undertake this. There was evidence in my research that the dialogue between osteopath and patient was important in capturing information. Patients stated that they did not know what information was important or that needed to be imparted and 'trusted' that the osteopath would ask the right questions:

*I think when you go to see someone that's a professional, whatever that profession might be, and they ask you a question I think there's an element of trust. You've got to trust that they're asking you the question for a relevant reason.*

(Agatha, patient, interview 17/2/17).

Students were concerned about capturing sufficient information but appeared comfortable in taking time and engaging with patients in a dialogue to check understanding and ask patients if they had any questions too. Osteopaths talked about the need for a dialogue with the patient prior to touching them to examine their bodies. This was seen as important in preparing the patient for the physical examination. The dialogue was discussed as not merely a brief conversation prior to the examination component but as encompassed within the case history taking, explaining what osteopathy might offer the patient and managing the building relationship.

The expertise of the practising clinician, able to undertake these aspects, mattered to some patients but not others. Being able to see qualifications in the form of certificates on the wall was generally seen as helpful and assisted patients in forming initial trust in the early stage:

*Coming in here, I looked at the qualifications on the wall - but that's because I understood what the qualifications were, so, in one sense it is important but in another sense if they were doing a good job and I trusted them they wouldn't be.*

(Aileen, patient, interview 29/1/17)

*I actually quite like the qualifications - I think it gives authenticity to somebody - not that you can't fake them. But I think it shows pride in what you do.*

(Scarlet, patient, interview 8/3/17)

Mechanic and Meyer (2000) describe how patients often use common sense reasoning by assessing qualifications as part of deciding to trust a practitioner. In this research study there appeared to be a presumption on the part of patients that the osteopath was qualified but there was no mention of professional regulation; this was only discussed by students and osteopaths. This is interesting as osteopathy is generally resourced through private healthcare as there is little available within the National Health Service. All registered osteopaths are listed on the General Osteopathic Council website ([www.osteopathy.org.uk](http://www.osteopathy.org.uk)) and most have online information which usually denotes qualifications and affiliations, yet patients did not seem to refer to these in this study. This is different from the findings of Waters et al. (2016) who explored orthopaedic patients' satisfaction with their care and found that association to a profession promoted a level of trust and Schattner et al. (2004) also found that patients attending a medical centre appear to value the level of experience of a practitioner. However patients in this study appeared to appreciate their own autonomy in seeking osteopathic care and it may be the availability of osteopathic care, the fact that it is predominantly privately funded by the patient and which they are required to source for themselves which explains this difference. A recent survey exploring reasons for patients seeking osteopathic care found that patients sought information about the benefits of treatment and evidence that it was effective, mostly sourced by word of mouth from General Practitioners or their social network (General Osteopathic Council, 2018b). Patients in my study cited word of mouth as the most effective tool in accessing osteopathic care.

So there appears to be trust in the professional presentation of the practitioner, in the first impressions that are made by the patient encapsulated by personal presentation, attire and the consulting space. In this research patients were less interested in seeing evidence of qualifications or sight of membership of professional bodies. The element of confidentiality and the concept of a 'safe space' were intrinsically important to all stakeholders, particularly with regard to the holistic nature of osteopathy where combined mind, body and spirit connections are incorporated into the consultation. All stakeholders appeared to respect the interpersonal relationship between osteopath and patient which appears to promote confidentiality and a sense of security enabling patients to divulge personal and private information. Osteopaths and students also acknowledged the requirements and responsibility for gaining sufficient medical information in order to practice safely, while patients stated they 'trust' osteopaths to achieve this. All stakeholders acknowledged the value of dialogue and touch as factors managing expectations and preparing patients for stages of the consultation. These facets provide a preliminary foundation to allow trust to form and on which a further relationship of trust can be built.

### Interaction and communication

The second theme that emerged from this research encompasses the interaction between osteopaths and patients and one aspect of this, the quality of listening, appears to be valued by all stakeholders in varying ways. Patients perceive being listened to as empowering, important on a deeply personal level, and both osteopath and student practitioners appear aware of this:

*I get a lot of feedback from my patients who've come in, they're you know, stressed, hassled, in pain - you sort them out over the course of the half an hour, three quarters of an hour, and at the end of it they get up and go 'God I feel so much better and thank you so much for listening to me!'*

(Sarah, osteopath, interview 7/2/17)

*When you're in a relationship with a patient, when you build the therapeutic relationship - it's all about, um, really listening to their story*

*and understanding how their pain or whatever they've come to see you for, how it's affecting their life.*

(Anna, student, interview 14/2/17)

The depth of inquiry, beyond just the physical presentation of pain, but taking into account psychological and emotional aspects, and allowing patients to express themselves in these domains is an aspect that both osteopaths and students appear fully aware of and all felt was important in the building of trust. The importance of listening is cited in healthcare guidelines and appears an important aspect across many healthcare specialties in terms of patient satisfaction with care (Bowman, 2013), practitioner values (Waugh et al., 2014) and ethical requirements (Cohen, 2006). The depth to which an osteopath will explore in order to gather information, listen to the patient, in order to be able to safely examine, diagnose and treat appears equally evident in this research. Within the remit of communication, the dynamics of hearing and listening, as separate entities, have emerged:

*So just listening, I think, implies that you just sit there and listen whereas in reality it's not just that - I think it's, it's more than just listening.*

(Ed, student, interview 15/2/17)

However, this 'dynamic' hearing and listening goes beyond just listening to what a patient is telling you. Students discussed listening for subtle clues and probing further in a dialogic way to ensure depth of understanding, while also showing awareness of the patient being knowledgeable about themselves. They described how engaging in a dialogue with a balance between being receptive and active in the conversation was frequently required. Patients expected to be given the time to talk and for the osteopath to listen to what mattered to them. Osteopaths expressed an awareness of applying the information to the patient presentation and taking account of the knowledge of the psychological and emotional issues when devising a treatment plan. They discussed how this enabled them to develop their understanding of the patient as a person and described how these components could affect all areas of the patient's health and wellbeing; this was also recognised by patients and was deemed important in acknowledging their feelings and emotions which required

trust. This echoes research in other healthcare spheres as Weis and Schank (2002) discussed the need for consideration of the full remit of biopsychosocial domains. I believe the development and nurturing of this in students throughout their educational journey is essential. As discussed in the literature review Gaiser (2009) states that this is most effectively achieved during group discussion where students can explore these skills and Purkerson Hammer (2000) cite the importance of developing these within the practice context. Stockley and Forbes (2014) emphasise how students value the practice-based element of the teaching clinic, and the intuitive and varying nature of listening skills may require this situational context in order to be developed effectively. The consequences of hearing and listening to a patient and using these skills to enable a patient to discuss their concerns appear to be powerful tools to develop a therapeutic relationship and engage deeply with a patient:

*...what was helpful there was getting beyond the physical, looking at how I felt about it.*

(Luke, patient, interview 8/2/17)

The different styles of hearing and listening appear to require the ability to adapt skills to varying situations and contexts and develop nuanced adeptness at managing the interaction. The ability to manage communication is a vital component of the consultation and requires many different skills and competences, which are used dependent on the needs and requirements of each patient interaction. Communication appears to require the need for adapting language to suit each individual consultation:

*But often things - like I've had patients that you've said, 'have you had any surgeries?' and they'll say 'no' and then you say, 'have you had any operations?' and they'll say 'yes' - sort of 'pins, plates, stitches' and then 'oh, stitches - yes I had my appendix out several years ago'. So, sometimes, it's, it's a prompting to get the information cause they've forgotten, or not understood....*

(David, student, interview 15/2/17)

*I feel with you - you, you do, you use the correct terms, you know, what everything is called, but you'll explain it in a way of which, kind of puts you on the same wavelength as me.*

(John, patient, interview 17/2/17)

The requirement for adapting language so it is appropriate to patients is evident in the Osteopathic Practice Standards (General Osteopathic Council, 2012) and this corresponds with a study by Wiggins et al. (2009) who found that patients appeared to value understandable terminology above many other aspects of the consultation. This ability to adapt language potentially improves the patient's understanding of their health and proposed treatment, but it also diminishes barriers between the professional and the patient in the sense that speaking a shared language and enabling understanding of information connects both parties and is a major component of building trust. Croker et al. (2013) state that this communication aspect is valued by patients and essential for the development of patient-centred care. In my study, students described how language, and the particular use of terminology could shape the interaction by providing positive or negative connotations. One student, Paul, reported how telling a patient that their back was 'weak' was inappropriate as the spine is actually a very strong structure; he explored the impact these words could have for the patient's understanding. Many students described the process of continual explanation of what was happening during the consultation process as a means of involving patients in the process and as a process of empowering the patient through understanding and involvement.

The effect of dialogue between the osteopath and patient appears to surpass mere passing of information but seems to provide an ongoing conversation which is personal and specific to the individual patient. Mechanic and Meyer (2000) describe clear and complete communication of information as a competence required to build trust, and this is important in gaining consent and developing patient-centred care. Gaining informed consent is a vital component of any healthcare practice. The need for this, and issues surrounding it, was also evident in the discussion around communication:

*And some patients just say 'James, I haven't got a clue what you're talking about, you're way too scientific' and I take the level down a bit. But that's good for me because actually that shows that if they're not understanding what I'm saying - am I really getting truly informed consent? So I come back and I explain it in less, you know, medicalised terms.*

(James, osteopath, interview 24/2/17)

The issue of informed consent has been in the spotlight in recent years and particularly since the Supreme Court judgement on the Montgomery case (United Kingdom Supreme Court, 2015) which resulted in a change to the law on informed consent where medical professionals are now required to ensure that patients are aware of any “material risks” involved in a proposed treatment, and of any reasonable alternatives. The implications for this have been incorporated into updated standards of practice within all healthcare regulatory documentation and to which all healthcare providers must adhere. The focus of this has directed attention towards greater patient-centred care in terms of patients' input into decision-making and taking responsibility for their own healthcare choices. This has required practitioners to enter into greater dialogue with patients and ensure that communication is effective and clear. In my research, osteopaths appeared aware that consent was patient-dependent in the sense that they opened a dialogue with patients, but it was the patient's right to make their own decision about what care they received. Osteopaths evidenced a clear understanding of informed consent and the changes in regulation while students appeared comfortable with seeking consent. They also considered consent, not just as a formal procedure but as a checking mechanism to explore patients' comfort with the consultation in terms of picking up on body language. Patients understood consent but discussed it in less formal terms, more as an explanatory process rather than a formal requirement.

The extent of the communication appears to be important, to ensure understanding of the patient's needs through the information that is provided, and then communicating back to them in terms they can understand what the osteopathic consultation can provide for them and starting the 'dialogue' to ensure a healthy relationship. Ensuring clarity in patients' expectations is

important in the first stage of the consultation and requires continual monitoring throughout the process:

*That's communication isn't it? You know - most patients, you know, number one priority for them is they want to know what's wrong with them, number two can you fix it? And educating the patient er, with dialogue they understand about their problem is a priority to help them know what's wrong with them ..... so it's a relationship we build.*

(Sarah, osteopath focus group 21/5/17)

Waters et al. (2016) describe how unrealistic expectations from patients can significantly diminish satisfaction with care received, but conversely by developing a good interpersonal relationship involving effective communication this can be less likely. Patients in my research described having varying expectations from osteopaths from gaining a diagnosis to how long it might take to improve their pain level. Students explored managing ongoing expectations through using dialogue to create communication strategies. They also expressed an awareness of communicating not just with words, but with their hands too as a form of interaction. Osteopaths seemed to take an overarching view on patient expectations by considering them as embracing all aspects of the consultation. They discussed approaching expectations at all stages from the initial introduction and explanation, fluidly through each stage of the interaction. This discussion embraced the nature of the individuality of each patient and the development of patient-centred care in maintaining a dialogue with patients and supporting them in making decisions. This might be important for teaching and learning as students naturally appeared to focus on individual aspects of managing patient expectations at various points of the consultation without the fluid linkages that the osteopaths expressed. This is an expected feature of less clinical experience and exposure but exploring the management strategies that osteopaths create might be beneficial in mentoring students to develop these skills. Pedersen et al. (2016) describe how the developing process of patients making sense of the encounter as it happens is important in whether their expectations are met and in the formation of trust. It appears that there are at least two facets to the management and impact of expectations on the building of professional trust – the patient's own assessment of the



encounter and the interpersonal relationship between the practitioner and the patient.

This research evidenced an awareness by all stakeholders regarding patients' vulnerability in providing intimate medical information, alongside undressing down in order to allow a practitioner to touch them to examine and treat. Providing reassurance was seen as an important part of the osteopathic remit and this was evidenced by the use of dialogue, body language and touch:

*But, yeah, I mean if you've got a pain anywhere and you can't see it you're going to want somebody to say, "oh it's nothing serious" or you know "look you've got muscle spasms here" or something. And to loose [sic] that and give you a bit of advice on it as well. Because I think when you are in pain you panic and you want reassurance from an osteopath or whoever you go and see.*

(Scarlet, patient, interview 8/3/17)

*It's, it's a, 'my hands are safe hands and you're in my hands - I'm going to look after you'. That's the sort of feel I try and give off I suppose.*

(Richard, osteopath focus group 21/5/17)

This need to be aware of patients' vulnerability and subsequent welfare, particularly in terms of power relationships, privacy and modesty was evident in discussions by all stakeholders. Mechanic and Meyer (2000) describe how patients are naturally vulnerable and this tends to make them cautious, particularly where they perceive any potential risk. They state that patients' willingness to trust practitioners in the early stages varies, but levels of trust build in tandem with experience. Osteopaths talked about providing reassurance through their touch, by initiating gentle touch and choosing techniques specifically for each patient. Students equally expressed an awareness of this and also mentioned using touch by gently laying a hand on a shoulder or arm to show comfort or support. Van Manen (1999) describes two aspects of touch: 'gnostic' touch as that which is used for palpation for medical purposes and is supported by clinical knowledge, and 'pathic' touch which is characterised by emotional and comforting components. Bjorbækmo and

Mengshoel (2015 p.9) describe how in physiotherapy practice these two elements enhance the therapeutic encounter and require practitioners to “listen and communicate through touch and movement”. This is similar to the findings of my study in that the dialogue between osteopaths and patients appears to be enhanced by a variety of styles of touch, used to enhance the clinical aspect of the encounter but also the interpersonal relationship.

With regard to vulnerability, particular mention was also given to the fact that patients undress to their underwear for osteopathic treatment and this vulnerable act was acknowledged by all parties. The vulnerability experienced by patients was mitigated by the ‘trust’ in the practitioner and their position as a healthcare professional. There was not discussion of other factors, either environmental or physical in relation to this, rather it was taken as an expected part of the consultation that was required to be undertaken. This may be particularly pertinent to osteopathy, where patients are required to undress to their underwear for examination and treatment and is therefore different from certain other healthcare fields, for example dentistry and pharmacy. Barnard (2016) describes how the power balance is one-sided and patients are dependent on practitioners to behave morally, ethically and in the patients’ best interests. He states that developing these appropriate attitudes and communicating effectively within each practice environment is complex for students to learn and advocates safe practice environments for students to learn these skills with peers and educators.

It therefore appears that the communicative aspect of the osteopathic consultation is vital in ensuring good hearing and listening skills and developing the creation of a ‘dialogue’ with patients. This appears to be the basis of a positive, safe and healthy therapeutic relationship incorporating patient-centred care and effective informed consent to develop trust between both parties. The vulnerability of patients, partly through the requirements to undress down to their underwear, but also through the mechanism of touch during examination and treatment, appear to require trust in the ethical and professional conduct of the osteopath. Dialogue and touch have appeared as important mechanisms for supporting patients through this vulnerability. They also appear to be key in managing patient expectations which seems vital at all stages throughout the

consultation and varying levels of confidence in achieving this were evidenced between osteopaths and students.

### Engagement and Relationships

The third theme incorporates engagement between the osteopath and patient and the relationships that form between both partners. The concept of time appears to be very important in enabling strong engagement and relationships. This was evident within the data and appeared as an important factor within the osteopathic consultation where osteopaths are able to provide longer consultation times with patients than many other healthcare practitioners. It was seen as invaluable in many aspects of the professional consultation in allowing patients time to express themselves, for osteopaths to have time to take a case history, examine and treat, and for both parties to get to know one another and develop closer therapeutic relationships:

*I think the lives we lead now are even so much more timed, that actually having that time to actually sit down with somebody to listen to you - I mean, I think some of the most moment [sic] times I've had here is when suddenly somebody just says, 'I'm so sorry' and they just burst into tears. Because finally somebody actually is just listening to what they're saying and seeing them as a person ..... I think we do allow them that opportunity and I think, because of that, we can treat patients very well.*  
(Sally, student, interview 14/2/17)

*You don't feel you've got to rush with the osteopath. You don't feel like you've got five minutes to explain your problem and then you're out the door - you don't feel that.*  
(Aileen, patient, interview 29/1/17)

Time is seen as important in other healthcare spheres (Berger et al., 2012) but it can be limited by constraints or demand on services. Waters et al. (2016) found that insufficient consultation time and the impression of feeling rushed led to dissatisfaction with levels of care, and Norberg Boysen et al. (2017) emphasise that patients need time to get to know and interact with a practitioner in order to build trust. This can be difficult for practitioners working in strict

timeframes, yet the osteopathic practitioner has a choice of length for appointment time and they generally provide patients with half an hour to an hour per consultation which affords the opportunity to dedicate time to the consultation. This increased time appears to afford an engagement which is seen to enhance and develop into therapeutic relationships and the building of trust whereby patients seek help and support from the osteopath:

*... he puts his health in your hands and obviously we have a little bit more time than GPs ..... we will have more time to talk and we can, you know, carry on, if the patient is ok with it, to talk through the treatment and this is how you build up that trust.*

(Henri, osteopath, interview 5/2/17)

This increased timespan seems to allow the osteopath to capture a depth of information and develop a focus on the patient, with their wants and needs at the centre of the framework. Patients reported the length of time as being valuable because it was focused on themselves, that it enabled them to get to know the osteopath and build a relationship more quickly and that it gave them time to talk, not just about medical problems but about personal issues that might be affecting their health. Students were equally aware of the amount of time enabling patients to have space to talk, but they also expressed awareness of the time it gave them as learners to re-check information and manage the patient interaction. Osteopaths described the power of the one-to-one setting and the time given to the individual as important and appeared aware that this was distinct to many other healthcare spheres. They also expressed an awareness that patients pay for that time and showed an appreciation of this investment by the patient. They discussed using the time fruitfully in capturing information and developing a rapport. It appears to enhance the ability to create and develop patient-centred care which is paramount in current healthcare (Katz et al., 2007). Time was valued as a particularly special aspect of the osteopathic consultation as a means of customising care and enabling focus on the patient:

*And they've got time. I think my major thing is time. You know, because you know life is led so fast nowadays and a lot of your time you give to*

*other people, but it's very nice to have somebody give you some time, so even like when it's hurting, at least, you know, you're having a bit of almost 'me time'.*

(Aileen, patient, interview 29/1/17)

*I mean that's a luxury, isn't it, we, that we can spend half an hour, three quarters of an hour, an hour if we want to? So, that makes our interaction time much more and our relationships much better with our patients.*

(Sarah, osteopath, interview 7/2/17)

It was evident in this research that patients highly valued the concept of space that the length of the osteopathic consultation provided in the sense that it was focused entirely on them. This appeared to be felt as special, that extraneous factors were left at the door and they seemed to feel an ownership of the time. This appears to have an impact on the formation of trust not only in the sense of the increased length of time, but in the focus on the patient. Croker et al. (2013) found that patients felt that having their interests and concerns taken seriously had the greatest impact on confidence and trust in General Practitioners. Norberg Boysen et al. (2017) also found that patients' ability to take their time during a consultation also increased their level of trust. In my research, the reports of being given time, being listened to and heard, feeling that the osteopath was focussing just on them, appeared strongly through the data. This indicates that they may be important to the building of trust in osteopaths.

The extra component of time seems to afford osteopathic practitioners the space to look at the 'bigger picture', thereby viewing the patient in a holistic way and the ability to explore the patient in this way allows osteopaths to investigate individual facets of a patient's presentation, from their physical, social and psychological spheres:

*I think, you know, you need to know the whole person and obviously what's going on in their, er, in their life can indicate their physical wellbeing as well as their mental wellbeing ..... if a particular event has*

*caused them stress, then you might need to know that because that might help you, er, treat them.*

(Timothy, osteopath, interview 16/2/17)

The use of the biopsychosocial model, which considers the biological, physical, psychological and social domains (Engel, 1977) has been evident in healthcare for the last forty years. It has been adopted widely in complementary and alternative (CAM) healthcare approaches and Van den Bruink-Muinen and Rijken (2006) found that patients reported attending CAM practitioners partly due to the expectation that a holistic approach would be taken and therefore their whole body would be treated rather than just a symptomatic area. Touch used in therapies which incorporate the biopsychosocial approach appears to enhance the therapeutic relationship and the effects of treatment (Elkiss and Jerome, 2012). Consedine et al. (2016) describe how touch within osteopathy reinforces the verbal communication and engenders trust due to its sensitive and communicative nature. The biopsychosocial model is evident in conventional medicine but as it requires time to explore all factors which might be affecting a patient's health, practitioners face time constraints due to increased demand for healthcare consultations and subsequent limitations of supply (Tuckett, 2015). Perhaps, here, osteopaths have an advantage due to the increased length of appointment time in which they can explore this dimension. Their ability to take a holistic approach to build an effective therapeutic relationship with the patient in this timespan, appears to be enabled through hearing, listening and questioning, not as a one-off occurrence, but as an ongoing dynamic that is nurtured and developed:

*... that whole thing, even if it's not at the beginning when you're talking - it can be when you're being worked on on the couch that you relax enough and a key question from the osteopath can open the door. So, again, I think it's skill on the osteopath's part not just to physically, but, you know, that knowing where to prod emotionally.*

(Maureen, patient, interview 31/3/17)

The engagement with a patient using a biopsychosocial approach is developed using dynamic hearing, listening and questioning through an effective dialogue,

but also requires a non-judgemental approach so that the patient can feel safe in expressing information. This is particularly important in developing trust, as patients need to feel that they can provide information without being judged or criticised and this has been evident in prior research (Rørtveit et al., 2015):

*I think it's also if they're compassionate. If you've got somebody who's interested in you and they're compassionate then you will reciprocate.*  
(Aileen, patient focus group 10/6/17)

The elements of compassion and a non-judgemental approach are prevalent throughout all professionalism guidelines and were discussed by many participants in this study. They appear in most definitions of professionalism, for example that published by the American Board of Internal Medicine (2002) and are an expected part of professional practice in all spheres of healthcare. A patient in the final focus group stated how important it was, as a patient, that questions were asked in a sensitive manner while at the same time ensuring understanding and that her needs were met. A student, Jo, talked about feeling empathy for patients and wanting to offer advice, but feeling that would be inappropriate. Students seemed to find the active listening harder to undertake on an emotional level, whereas osteopaths appeared more comfortable with this. Much of the research surrounding trust in healthcare cites empathy and caring as important to the formation of trust in practitioners (Dickert and Kass, 2009; Mechanic and Meyer, 2000). Van den Bruink-Muinen and Rijken (2006) found that a caring and empathetic attitude was equally as important to patients as successful outcomes from treatment so the interpersonal and affective components of care and the building of trust in these areas are vitally important. As students, understandably, feel less secure in handling this area of practice it appears critical that they are educated and supported in developing these aspects of practice and components of professionalism.

An important aspect of the osteopathic consultation is that it is not free at source and this is vitally different from care that is sourced within the National Health Service. This can have a profound effect on the engagement and relationships between osteopaths and patients in the sense of expectations of service and issues of ongoing care. Patients seek osteopathic care for many

reasons, some of the most important being relief from pain, an understanding of their health and reassurance regarding this (General Osteopathic Council, 2018b). Patients discussed expecting treatment and an understanding of the pain they were experiencing alongside help and reassurance. This requires an effective dialogue alongside a hands-on approach in managing patients' expectations. Osteopaths work in private healthcare and charge a fee for their services. This not only means that patients have potentially had to source their services, but that they come with particular expectations:

*...they've had to find us, figure out how to engage with us through their own proactive - I mean it's not like we've gone to them and said, 'come in to my clinic!' {laughing} 'I can do something for you'. So they've already made a lot more, er, conscious activities to engage with us and then they've put their money down. It's a big thing.*

(Clara, osteopath focus group 21/5/17)

This engagement by the patient in sourcing osteopathy and paying for treatment is a huge contributing factor to a patient's motivation, expectations and desires for the therapeutic interaction and enhances the importance of trust in the professional practitioner as patients are paying a fee for the service. The impact of patients not only sourcing osteopathic care, but also paying privately for each consultation is important in the sense that it appears to have an impact on their motivations and potential ability to continue osteopathic care. The time is therefore important in a financial sense in that patients may feel the need for 'value-for money' although it was interesting that this was not mentioned in my research. Pedersen et al. (2016) discuss how alternative medicine at present has limited scientific evidence and therefore the trust that patients have in practitioners working in this sphere is particularly important. The level of scientific evidence was not discussed by participants in my research and all stakeholders appear to value building therapeutic relationships with a focus on the patient as an individual and developing a holistic biopsychosocial approach to patient-centred care. This ongoing construction of relationship building with investment on both parts in terms of the patient paying for the consultation and the osteopath endeavouring to provide time, depth of inquiry focused on the



patient through dialogue and touch appears to develop the formation of trust within the evolving relationship.

### Customised Approach

The fourth theme encompasses a customised approach which constitutes the adaptation of the consultation to the individual patient whereby the osteopath adapts their contact, both verbally and physically, specifically to each individual. This appears to involve making choices on how to conduct the taking of the case history, examination and/or treatment and their overall interaction with the patient. This adaptation seems to be informed by feedback, both verbal, non-verbal, visual, through body language and intuition and appears to be important, particularly in terms of the physical interaction aspect of the consultation.

Both students and osteopaths discussed the 'intent' prior to any interaction with a patient, particularly prior to touch:

*But you have to be very careful about your intent always all the time because it's hugely intimate so you're, on one hand you're being extremely intimate but on the other hand you've got to maintain, sort of quite a wide boundary there I think as well.*

(Flora, osteopath focus group 21/5/17)

*I think you can communicate in different ways depending on what your intention is. And being aware of that is really important when you're with a patient. That's the first thing that came into my head. "What's my intention when I'm touching that patient?"*

(Anna, student, final focus group 25/11/17)

This concept of 'intent' was particularly related to touch in the osteopathic consultation and this is beginning to be researched (Consedine et al., 2016; Elkiss and Jerome, 2012). The thought process, rationale and purpose prior to laying hands on a patient were evident in both students' and osteopaths' thoughts. This was connected to an understanding of the individual patient presentation and the engagement and relationship built with the patient to that point. Krot and Rudawska (2016) describe trust as formed from the faith in a

practitioner's intentions and this thought process preceding the adaptation of a therapeutic approach to be customised to a patient is evident in guidelines for healthcare practitioners, for example Standard A5 in the Osteopathic Practice Standards (GOsC, 2012). This is potentially critical for osteopaths who use their hands both to evaluate and treat patients thereby creating extensive time periods when they are using touch within the consultation. The need for osteopaths to ensure patients are provided with a clear explanation for each component of the consultation, particularly the hands-on element, but maintaining a dialogue and gaining feedback from the patient appears to be very important. Osteopaths and students discussed the importance of verbalising their rationale for examination and treatment both prior to undertaking these but also during the process.

*It's about making sure that the advice and I guess the treatment you give is tailored to that patient - it's not just general advice. It's on the back of understanding what's going on...*

(Student, unfacilitated student focus group 9/7/17)

*I think one of the skills you develop is being almost chameleon like - and adapting to that patient and you notice something about the way they are, or the way they talk and that's, you mould to suit them, rather than just be who you are.... Because to me, that's professionalism - I am being a professional and adapting to that patient. And becoming what that patient likes in essence.*

(Richard, osteopath focus group 21/5/17)

Patients, understandably, did not seem to be aware of this occurrence as a behaviour or action undertaken by the osteopath, yet they did expect that their specific needs were addressed. Patients did not seem to have considered how that might be undertaken. Osteopaths and students described this adaptation as informed by body language and feedback, gained from visual, aural and tactile sources. This is similar to other healthcare spheres which require practitioners to be alert to non-verbal signals, for example the Nursing and Midwifery Council Code of Practice (2015), and this adaptation was keenly evident in this research:

*But all those things are layered up for you, how you're interpreting them and their situation and how they're going to respond and, it's body language but through tissue and palpation as opposed to posture.*  
(Clara, osteopath focus group 21/5/17)

All participants appeared aware of body language, both their own and that of other parties. Aileen, a patient, described noticing body language and being aware that osteopaths would be aware of her own too. An osteopath described how it was necessary to monitor patients' body language in how they responded to touch to gauge their reactions as a tool to inform further examination and treatment. This concurs with Pedersen et al. (2016) who found that practitioners in alternative medicine pick up on body language as signs of confidence in the practitioner and the success of building trust. The physical interaction is a huge part of the osteopathic consultation as osteopaths treat with their hands. In my research the use of touch initially appeared to be almost taken for granted by all stakeholders as a presumed and silently acknowledged part of the process. Patients discussed the initial trust required for touch to be undertaken:

*And you're trusting somebody as well, so you've got to be able to trust or feel that you can trust that person. Cause [sic] you're maybe telling them intimate details, you know, I mean you're letting them touch your body which is intimate.*  
(Aileen, patient focus group 10/6/17)

Alongside the initial trust required is the issue of consent that is required for touch to happen and this is prefaced by communication before touch can be initiated. Consent is vital at all stages of the consultation but prior to the laying on of hands it appears to be viewed by practitioners as particularly important. Osteopaths described the need for ensuring patients were clearly informed about each step of the examination and treatment. Students were equally aware of the need for this and also the power of involving patients in the discussion regarding examination and treatment, thereby developing a professional relationship between practitioner and patient. This appears to

show that the dialogue is essential to ensure communication lines are open and effective and that patients were primed for the hands-on elements of osteopathic care. This appears to demonstrate a patient-centred approach by both students and osteopaths:

*To me, I think some of the professionalism that allows that level of touch comes before touch. So it's building, it's within taking the case history, it's within the whole understanding and educating patients maybe on what is expected from osteopathy that then allows you to be able to, you know, to put your hands on to touch, to do all the treatment and comforting and those kind of things. I think a lot of what allows that comes before the touch actually happens.*

(Samuel, student, final focus group 25/11/17)

*I suppose to kind of summarise it I suppose: the patient is the person who chooses whether it's appropriate or not appropriate, but you as the practitioner have the ability to educate, help and create those barriers and form that. And if you're a good practitioner you can do it really well and if you're a bad practitioner then you'll be struck off! {laughing}.*

(Richard, osteopath, final focus group 25/11/17)

This ability to monitor the physical interaction, gather non-verbal signs and manage the consultation in a manner appropriate to each individual patient is a requirement of competency in healthcare practice, and evident in Standard A2 of the Osteopathic Practice Standards (GOsC, 2012). In this research, osteopaths and students discussed patients' awareness and reaction to touch alongside their vulnerability at this critical point of the therapeutic consultation, how touch can open up emotions and how each patient's individuality or uniqueness requires a different physical approach:

*We are quite unique still, um, in that capacity because we do spend a lot more time with our patients than a lot of other medical professions. And we do so in what can be perceived to be quite an intimate setting, you know. It's usually a one-on-one consultation where one person is often*

*in their underwear and, you know, I, as a practitioner might well have my hands on that person's body.*

(James, osteopath, interview 24/2/17)

*And then obviously you're physical with them very early on, so as soon as you've taken the case history you're actually physically touching them, um, and that I think research has shown has, has meant that people have kind of completely melted and opened up. Probably more than sitting in front of a psychiatrist or something.*

(Jane, student, interview 24/2/17)

The power of all the different facets of touch require the need to monitor and check patients' responses to touch to ensure their welfare and maintain a healthy therapeutic relationship. This is an important part of practitioner responsibility to ensure the physical and emotional welfare of the patient and is evident in guidelines and research (Schiff et al., 2011; Leder and Krucoff, 2008). It has been a focus of educational curricula to ensure that students develop the skills to achieve competency in this as many referrals to Professional Standards Boards are in this remit (GOsC, 2015a) as discussed in Chapter 1, p.9. In this research participants discussed the monitoring as starting with a general screening but developing feedback and an awareness of communication through touch:

*I think it's also, it's also going to be monitoring how the patient responds to any touch ..... So it's being really aware of how people react to what you're doing and adjusting and being able to adjust.*

(Samuel, student, final focus group 25/11/17)

*"The same with the touch ..... it's about meeting the patient with the touch. So the touch is the communication."*

(Anna, student, final focus group 25/11/17)

Touch as a communication tool is evident in many spheres of healthcare (Kelly et al., 2017) and requires careful instruction, development and monitoring for students in the teaching clinic through observation, mentoring, supporting

reflection on experience and group discussion. In this research it was particularly seen as acting as a physical conduit through which communication, emotions, connection and trust are enhanced:

*..... you're actually physically touching them when you, when you're talking to them. So you tend to build a rapport quite quickly and I find that they'll be more willing to offer information they might not necessarily have told you in another way. So I think it does help communication most of the time quite a lot.*

(David, student focus group 7/5/17)

*It's almost like our physical interaction is a sort of almost like a conduit into having difficult conversations, isn't it?*

(Finlay, osteopath focus group 21/5/17)

As Finlay mentions above, the power of touch appears to enable the opening up of conversations and the development of the therapeutic relationship which dialogue alone cannot form. In this research in osteopathy, it shows a link between dialogue and touch as reinforcing one another and creating a powerful dynamic interplay. The impact of touch with the variety of sensations that it induces, appears to affect the dynamic between practitioner and patient and potentially create a deeper form of communication.

There appears to be a requirement for the osteopath to develop a level of intuition within their practice in order to pick up on body language, aspects of communication and touch as to how the consultation is progressing. This is evident in all healthcare spheres and has been discussed as a key component of evolving proficiency in the developing student journey (Wagner et al., 2007; Dall'Alba and Sandberg, 2006). As discussed in Chapter 2, p.25, Baernstein et al. (2009) described how students value the intuitive nature of medical practice and value the learning in this environment. This is important as mechanisms need to be created to ensure that students effectively learn these subtle skills and this will be discussed further in Chapter 6. Touch appears to be a complex quality in terms of the variety of sensations and emotions that it induces and this may be particularly pertinent to osteopathy in that practitioners use touch for the

process of evaluation and treatment and for longer periods of time than some other healthcare practitioners. The implications of this can potentially affect the outcomes that occur:

*I think it's basically the balance between everything, it's like you want me to know that I know what I'm doing, you want me to be firm and in control, but you also want me to be sensitive and tender and not invasive. But you also want me not to be, not blasé about what I'm looking at, you know if I'm looking at your back and you've got your top off and you're in your bra, you almost want that to be second nature. But then you also want me to be sensitive to the fact that you're in your underwear and you're vulnerable. And it's that, it's that borderline between hitting all these things.*

(Richard, osteopath, final focus group 25/11/17)

This indicates a potential complexity in managing all aspects of the consultation and a diverse array of skills that require to be undertaken with a level of expertise for a successful outcome. This is likely to require experience but also the ability to build knowledge through learning in practice, as discussed by Dall'Alba and Barnacle (2007) in Chapter 2, p.26. The impact of this for students in developing this complex array of skills is important as curricula need to ensure they provide the time and opportunity for students to reflect on their development of these skills and this will be discussed in Chapter 7. Richard discusses above how dialogue and touch are used in a fluid manner in an intuitive and reflective form as key tools in balancing the interaction and ensuring that patients feel comfortable and supported during the interaction. These appear to be important elements for creating trust as they appear to require the element of intuition which is combined with feedback in various forms, both visual, aural and tactile. This can be complex for students to learn and develop in the teaching clinic, yet the senior students in my research appeared to feel comfortable with this concept.

*I think quite a lot of the time you just have a feeling - that intuition - I don't know what it is whether it's a combination of things or, their eye contact*

*or, I don't know, you can just immediately sense whether it's going well or not.*

(Ed, student focus group 7/5/17)

This feedback within the osteopathic consultation is viewed as enabling an individually adapted consultation which provides a more customised approach to the patient:

*I'd say it's the nature of the day, the nature of the patient, the nature of your mindset - everything. There's a whole amalgamation of factors with each patient and they can be quite fluid as it happens.*

(Sarah, osteopath, final focus group 25/11/17)

*It's interesting - I had a patient this week who said to me "do you go on new courses and learn new things cause I come in every three or four months and every time I see you you're always treating me differently, always doing a slightly different technique or you treat me in a very different way". And my response is "I'm treating you - I'm treating how you are when you walk through that door at that point in time".*

(Richard, osteopath, final focus group 25/11/17)

Therefore it would appear that the osteopathic consultation contains a focus on the individual patient with an aim of providing a customised approach using feedback via many sources integrated together to adapt and tailor the professional approach to each individual patient. The intent, prior to touch, and the communication through dialogue preparing patients for touch appears to be understood by osteopaths and students. The use of intuition in adapting approaches to individual patient presentations appears to require a developing level of experience. In osteopathy, this appears to be fostered through a complex array of skills, managed in the practice context by feedback through verbal means, but also through body language and feedback through touch. The element of touch in this sphere is particularly important in managing and mediating the formation of trust and I feel this needs to be reflected on in greater detail by practitioners and developed further and supported in the



educational process for students. Suggestions for this will be included in Chapter 7.

### Empowerment and Education

A key part of the osteopathic consultation is perceived to be the partnership that is formed between the osteopath and patient and the empowerment and education of the patient which develops. This is dependent on the motivation of the patient in sourcing osteopathic treatment, the increased consultation time, the hands-on treatment approach and the dialogue between the osteopath and patient in discussing findings and engaging the patient with actively participating in managing their health:

*...the long-term outcomes - having them involved in their care, I mean, from an informed consent point of view that it's, it's not a paternalistic relationship - it's collaborative with the patient to get what they want, what the best outcome is for them and sort of tied with their goals and self-care strategies.*

(David, student, interview 15/2/17)

*An osteopath will get you to your body and you get used to what is happening and if you start feeling a difference and you're working together to achieve, um, the same goal then it is a partnership.*

(Scarlet, patient, interview 8/3/17)

The focus on patient-centred care is paramount in guidelines for good healthcare and is strongly evident in educational curricula to ensure that students entering the profession have the relevant knowledge and skills to fulfil this requirement (Bleakley and Bligh, 2008). This is developed by providing students and practitioners with strategies to promote patient participation and empowering patients through knowledge:

*I think it's just reciprocal. I just think, you know, there's so much knowledge on the part of the osteopath and the expectation of the patient and I think each feeds the other. The patient feeds the osteopath with*

*their problems - the osteopath feeds the patient with potential answers and they sort of meet in the middle.*

(Maureen, patient, interview 31/3/17)

The partnership between osteopath and patient, working together, promotes a shared responsibility to the patient's health and wellbeing and to their development and return to health or function. Wilk and Platt (2016) describe how patient involvement is equal to that of a practitioner and can influence not only the success of a patient-centred approach but the development of trust between practitioner and patient. This shared responsibility and partnership requires equal engagement for best effect but it appears to be the responsibility of the practitioner to ensure that they communicate effectively and educate patients about the benefits as Anna, a student, described:

*..... it's about being clear at the beginning about what you can do for the person. But it's also about clear, about being clear about what you expect them to do for themselves, what you suggest that they do for themselves.*

(Anna, student, interview 14/2/17)

A major aspect of this partnership appears to require a focus on the osteopath 'empowering' the patient and this is seen to be achieved through the creation of strategies whereby the osteopath provides the patient with particular knowledge or skills in order to take on some responsibility for their own healthcare and improving their health. Osteopaths and students described this by using touch to educate patients about their bodies, showing and practising remedial exercises and teaching self-care strategies such as breathing techniques or stretching exercises. All of these require an effective dialogue to explain and check understanding while gaining feedback from patients as to their effectiveness and many require a direct hands-on approach to enable patients to learn these successfully. Patients appear to value these approaches greatly:

*Yeah, well if an osteopath gives you exercises to do you've got to try and do them, but I'm not very good at that, I know that! {laughing} Um, but, no you do have to be willing to play your part as well, don't you. Say the*

*osteopath says, 'you need to get a bit more exercise' then maybe you need to start thinking about that.*

(Joy, patient, interview 4/4/17)

*As an approach, I think it's absolutely brilliant and I think that's part of the whole success of osteopathy is that you're not just doing what's there - you're trying to get that person to appreciate that there's many things that have contributed to them coming to that point. And they have an ability to influence it themselves.*

(Keith, student focus group 7/5/17)

Osteopaths and students spoke positively about this aspect of their practice. Training students for educating the patient is an integral feature of educational curricula, so while students are learning they are also being developed to educate the patients of tomorrow. Providing students with the knowledge and skills to educate others is seen to strengthen their confidence in managing the progression of treatment, patient expectations and setting appropriate and achievable goals (Aguilar et al., 2012). Osteopaths and students described the process as empowering patients. Pulvirenti et al. (2011) describe empowerment within patient-centred care as dependent on the sociocultural context, the patient's knowledge and experience of their health and the impact of barriers to their engagement. This, then, might need an effective dialogue in order to explore these factors. Patients appear to value being given knowledge and osteopaths and students value the educational aspect of their role. This empowerment leads to facilitation and the creation of a 'legacy' to enable patients to care for themselves on an ongoing basis:

*I think that, that there is an element of that, that we do need to, you know, give people back that power about themselves ..... you know, we're not trying to turn them into osteopaths but we're trying to turn them into experts on themselves. I think that's what it is really.*

(Hope, osteopath, interview 2/4/17)

*I think the one thing that, er, I've enjoyed and again the part of the fact that we have so much clinic hours is this whole concept of educating*

*your clients. And educating, educating and educating - and being able to communicate and articulate in a way that they can understand what the problem is.*

(Keith, student, interview 19/2/17)

*You know, although you are a 'patient', in inverted commas, you are also a person underneath - a person in pain - and you have your own answers but you don't know it, so in a way it's like you're learning - you're learning to treat yourself which is a good thing - I think it's a very good thing.*

(Aileen, patient, interview 29/1/17)

Involving patients in their care, their return to health and providing them with knowledge appears to empower them in taking responsibility for their own health. This is evident in all spheres of healthcare and Richards et al. (2015) discuss the effectiveness and empowerment of aiding patients to manage their own health rather than being purely dependent on healthcare practitioners. Barr et al. (2010) discuss the demand for greater public involvement in care and state that patient inclusion in learning about and improving the delivery of patient centred care. In my research, osteopaths and students expressed awareness and a level of skill through a developing relationship between practitioner and patient that forms a legacy of care outside of the consultation room and which the patient takes away with them. Patients perceived this as a powerful part of the consultation, that continued their perception of care after the treatment session ended. They described this as empowering and educating, providing them with knowledge and confidence.

This research has uncovered the PIECE five-stage theory of professional trust in osteopathy which encompasses developmental elements capturing staged processes of the osteopathic consultation: practitioner presentation and representation (Personal approach); interface and communication skills (Interaction and dialogue); relationship building and holistic approach (Engagement and relationships); adaptation and physical conduit (Customised approach); partnership and learning (Empowerment and education). These

areas are entwined with the constant dialogue between practitioner and patient and the element of touch which has a profound effect on the whole encounter.

The skill-set within this five-stage model are all elements to be found in an osteopathic educational curriculum but to varying degrees and taught and learnt in differing ways. Their combination together can be found in requirements for final year students for example in clinic reports, but the nuanced focus on dialogue, and most particularly the awareness of touch, and how these interact with other competencies may not be so evident. The inclusion of patient input into this research has also been particularly compelling as patient feedback, although sought through patient focus groups and patient satisfaction questionnaires in the teaching clinic, have not captured the depth of information that has been gathered through this research. The next section will discuss this new theory with regards to implications for the profession, consequences for learning and teaching and suggestions for educational tools for osteopaths and students to enhance their understanding of professional trust in osteopathy.

## **Chapter 6 Discussion**

This research set out to explore a theory of professionalism in osteopathy, as this did not seem to have been undertaken previously. An initial pilot study uncovered the values and attitudes which appear to be important to osteopaths, students and patients. The subsequent main study utilising Constructivist Grounded Theory further explored osteopathic stakeholders' perceptions through interviews and focus groups to seek an understanding of what professionalism constitutes in osteopathy, how it is perceived by all stakeholders and in what ways it is enacted in practice.

What emerged through this study has not been a theory of 'professionalism' but a comprehension of osteopathic professional trust. The research has shown how trust is developed, built and enhanced through the relationships which are fostered between osteopaths and patients in the course of the osteopathic consultation. Using the findings from this research I have created the PIECE model for professional trust in osteopathy. The five defined themes describe the components that osteopaths, students and patients expressed as important in the formulation of trust within the osteopathic encounter: personal approach; interaction and communication; engagement and relationships; customised approach; and empowerment and education.

Trust has historically been a difficult concept to define (Monrouxe et al., 2011; Goudge and Gilson, 2005), and Meyer et al. (2008) claim that it appears to be an evolving process that is not fixed but which develops and grows, potentially for the better or worse. This research has uncovered a theory of what it means to osteopaths, students and patients within the osteopathic remit and it appears to consist of many subtle constituents within the clinical interaction within particular nuanced spheres. This research has shown that it may be very important for osteopaths and students to be aware of these and continually develop effective skills in order to manage and maintain good professional trust in practice, and suggestions for this will be made later.

The research questions I set out to explore were as follows:

1. How do the beliefs and values of osteopaths, students and patients form their individual concept of osteopathic professionalism?
2. Is there a consensus of osteopathic professionalism amongst all stakeholders in the osteopathic remit?
3. How does an osteopathic theory of professionalism compare with those of other healthcare modalities?
4. How can the theory of professionalism be taught to osteopathic students?

I shall explore each of these in turn in relation to the findings from this study and by using links to research.

*Research Question 1: How do the beliefs and values of osteopaths, students and patients form their individual concept of osteopathic professionalism?*

The decision of a person to trust has been described by Mechanic and Meyer (2000) as based on intuition and gut feelings. Calnan and Rowe (2006, p.352) describe it as “forward looking” through the hopes and expectations of a patient. The criteria for developing trust in healthcare interactions are wide and Meyer et al. (2008) describe trust as forming through significant relationships, the nuances of which are often unrecognised. The theory that has emerged through my research concurs with both these elements in the sense that professional trust in osteopathy is dependent on the developing and maintaining of effective, therapeutic relationships between osteopath and patient. However, I add to these in the osteopathic context in that they are also supported and affected by the elements of dialogue and touch which enhance and mediate those relationships over time.

In the osteopathic sphere the personal presentation of the osteopath appears to be important in their attire, environment and professional approach although there was no consensus surrounding these. They were described as variable by participants and there was an acknowledgement by osteopaths and students that practitioner individuality was appreciated. They valued the variety of treatment approaches and there was a strong aversion between osteopaths and students to conformity. This may be similar to research in the main medical

model as Wiggins et al. (2009) found that a neat appearance was respected by patients. It is unknown how the elements of uniqueness and a perceived lack of conformity relate to other healthcare spheres. Perceptions of trust within different demographic portions of the population seem to vary (Wilk and Platt, 2016) so the uniqueness and availability of choice of practitioner may benefit the building of trust (Meyer et al., 2008). This is important in my own study as there are a variety of facets which appear to make up osteopathic professional trust and the authenticity of practitionership is a component of this. The ability for the patient and osteopath to connect on a personal basis and form a unique relationship going forward appears to be key in building a professional trusting relationship. Although discussion did not develop around specific cultural themes, the conversation encompassed a wide discourse on the personal attributes of osteopathic practitioners and the breadth of osteopathic practice. Therefore, although the understanding of trust and what it means to each participant can be difficult to define, it can be understood in a sophisticated sense to be linked to a developmental and transformational process from an initial individual presentation towards the development of an effective interpersonal relationship.

This appreciation of the unique osteopathic practitioner appeared to be balanced by an awareness of first impressions and how this might affect patient perceptions. In this research participants discussed the 'blind trust' at the outset which appears to be dependent on preconceived expectations and personal attributes of the individual practitioner and this has been deemed by researchers as an assumption of trust based on the perception of professional competence (Wilk and Platt, 2016). The practitioner is perceived to be initially responsible for this perception, it is also dependent on the developing relationship and partnership between patient and practitioner and this appears key in developing trust. Meyer et al. (2008) describe this relationship as a lens for viewing the development of trust as it can highlight particular dimensions of relationships in terms of subtle areas of responsibilities or skills. This has been evident in my research which shows that there are a range of key areas, involving interpersonal skills of hearing and listening, to the use of dialogue and touch, which are all important both in and of themselves, but also as a collective developmental process to engender trust in the osteopathic practitioner. This



research has also shown that professionalism and trust in the professional practitioner are not static, as discussed by Bryden et al. (2010) in Chapter 1, p.10, but continually evolving and developing. The situational nature of practice, as discussed by Hordichuk et al. (2015) in Chapter 2 appears to be critical in shaping the development of personal trust. Each interaction with a patient is individual; it requires the practitioner to adapt and change to each situation using a variety of interpersonal skills.

Douglass and Calnan (2016) describe particular interpersonal skills – comforting, caring, explaining and listening – as vital to the formation of trust in healthcare. Patients in my research mentioned these components and also discussed compassion and a non-judgemental approach as important within osteopathy. The findings in this research appear to refine these further within the osteopathic domain where the actual ‘dialogue’ between practitioner and patient, allied with touch as both a clinical tool alongside an empathetic and supportive process, enhance the interaction between participants within the osteopathic consultation. The two mediating processes of dialogue and touch seem to enhance all these components by reinforcing or expressing, either verbally or physically, at any stage of the osteopathic consultation and this seems important to the development of trust.

The interpersonal competence of building trust, in the form of developing effective relationships, has been seen as a skillset rather than a personal trait and Mechanic and Meyer (2000) state these are skills which have the potential to be taught and learnt. In order to develop trust, patients expect practitioners to be competent, but this is not just in terms of technical competence; the ‘soft’ skills also appear important, for example listening, reflecting on feedback and understanding the patient. Schattner et al. (2004) describe how patients appear to value practitioner expertise and good communication for the development of trust and this is an interesting focus on behaviour as the historical debate into professionalism in the medical sphere has ranged between the utility of values, attitudes or behaviours as best representing the underlying tenets or visual expressions of professionalism in practice as discussed in Chapter 2, p.19. There has been much criticism regarding professional behaviours as unreliable mechanisms for portraying

professionalism or their utility for assessment purposes (Van Mook et al., 2009a; Rees and Knight, 2007) amid claims that underlying values and attitudes have been much better at portraying evidence of core professionalism (Aguilar et al., 2012). This has ramifications as to whether knowledge of professionalism can be *taught* as a 'skill-set' or whether personal 'trait' values are in fact more important. My research has actually indicated that the personal values of the osteopath are indeed very important, are picked up on by the patient and valued by both in the encounter. The components of professional trust are indeed skills, but participants in this research indicated that they are required to be absorbed into the entire consultation and to be undertaken fluidly in practice. This indicates the need for an adaptive process tailored to each individual patient consultation, and it also requires the osteopath to be able to justify their decisions and actions taken so they do not become blurred by the complex and multiple facets of the encounter. This is not just to adhere to guidelines and protocols but as Zijlstra-Shaw et al. (2012) discuss, as a method for the individual to account for their actions and decisions. Cruess and Cruess (2010) as mentioned in Chapter 2, p.22 state that adaptation is essential in continually improving skills. Osteopaths and students in this study indicated an awareness of this and an ability to continually re-evaluate their skills and the development of professional trust in practice.

So it appears that the values that underpin practice are important and valued, not just by osteopaths and students, but by patients too. These are enacted in practice through behaviours, but the fluid nature of osteopathic practice and the adaptive process required potentially complicate defining the requirements for professionalism and professional trust into named behaviours. The situational nature of practice and uniqueness of each patient presentation indicates that in the osteopathic sphere it requires a deeper understanding of what all participants value within the interaction to define what 'matters' to all stakeholders. The two key elements of dialogue and touch that have emerged through my research and which encompass and enhance all elements of the consultation process are complex to define and appear to be used intuitively in practice. Reducing them to a restricted definition would not only be challenging, it might limit their role in practice.

In my research participants mentioned a 'safe space' which appeared to be an important factor when first consulting with an osteopath. This seemed to form through the growing interpersonal relationship to create a form of trust which enabled patients to feel assured of confidentiality and security. Healthcare consultations are a form of social interaction where relationships develop and build so that trust can be built over time (Mechanic and Meyer, 2000). They describe how patients are vulnerable actors in this process and trust requires to be built through experience, developing more in the long term than in short term relationships. This is key at first meeting where patients make presumptions that practitioners are competent at the outset and make a decision to trust with little prior knowledge. The concept of the 'safe space' appears to emerge from the trust that is formed between the practitioner and patient and which incorporates sufficient time for trust to develop, a non-judgemental approach, respect and listening (Kisfalvi and Oliver, 2015). The opportunity that osteopaths have with the length of consultation time potentially optimises their ability to listen and develop the relationships requisite for this. The importance of osteopaths developing effective interpersonal skills to enable the formation and maintenance of strong therapeutic relationships seems important to enable patients to feel safe in expressing private information.

The facets of hearing and listening appeared important to all stakeholders in this research and osteopaths and students discussed many methods of adapting these skills to different situations. This seemed to enhance the ability to create a 'dialogue' between osteopath and patient which leads to the opportunity for developing patient-centred care. Hearing and listening are described by Rørtveit et al. (2015) as essential components for building trust with patients and for developing an effective, holistic relationship. They also discuss the need for confidentiality as critical in this remit. Waters et al. (2016) also describe the importance of listening but acknowledge time constraints as barriers to the effective undertaking of this. The ability of osteopaths to potentially provide the time for this important aspect increases their ability to develop and nurture these skills.

Listening appears to not only be a powerful tool to enable patients to talk but also to provide osteopaths with the ability to hear patients' reports of their health

and concerns, both physical and emotional, to integrate these and explore them through dialogue, but also through examination and eventually treatment. The act of listening is a respectful process of information collation, but also a processual act which informs communication and shared decision making.

Pedersen et al. (2015) link dialogue, time, listening and openness as important features to the building of trust in alternative medicine and this appears to be borne out through my research in osteopathy. In addition to these components I would add the important facet of touch as an equally core component to the building of trust.

The element of touch appears to be equally as important as dialogue within osteopathy. Touch appears in one context to be taken for granted by all stakeholders in the sense that osteopaths use it each day as a fundamental component of practice; students develop palpatory skills iteratively as a core element of learning the craft; patients attend osteopathic consultations with the expectation that they will receive osteopathic treatment at the hands of the osteopath. However, exploring perceptions through this research showed that osteopaths are keenly aware of the impact of touch, both 'gnostic' and 'pathic' (Van Manen, 1999) and sense the complexity of how these are used in practice. Students seem to be aware on a slightly less experienced level of the impact of touch but showed insight and proficiency as to ways it can be used. Patients, while not being aware of how the osteopath uses it, appear to depend on the trust held in the professional integrity of the osteopath when allowing touch. Osteopaths and students were keenly aware of the ability for touch to act on many levels, not just as an evaluative and treatment tool. They expressed understanding of how touch is communicative, empathetic, reassuring and educational. Patients reported the feeling of vulnerability at the start of the consultation and prior to touch but discussed how osteopaths communicated and used touch sensitively to enable trust to develop. Research in osteopathy is showing increasing awareness in how touch mediates the interaction between osteopath and patient. Elkiss and Jerome (2012 p.515) describe how touch can create a 'tactile dialogue' between patient and practitioner, while Consedine et al. (2016) describe how touch can engender trust through its sensitivity and as a physical form of communication. Both these studies

indicate the communicative aspect of touch and how it can function in the formation of trust in osteopathy.

Osteopaths and students in my study described the need to monitor patients' responses to touch as a form of professional responsibility and care. This seemed to be formed through an intuitive capability where practitioners pick up on body language and feedback from touch. Intuition was seen as important by all participants in my research in the sense that first impressions were important at the outset, but body language was also analysed throughout the consultation by all stakeholders. Feedback, gained visually, aurally or by touch, was particularly valued by osteopaths and students in assessing and monitoring the success of the patient interaction at all stages. Rørtveit et al. (2015) discuss how nurses demonstrated the development of trust through opening space to talk, being familiar with patients' backgrounds, promoting shared decision making, being caring and non-judgemental and providing a personal approach. These indicate listening and communication skills but do not add the element of touch as a monitoring tool. Elkiss and Jerome (2012, p.517) describe touch as "bidirectional and reciprocal" in the sense that the 'toucher' is 'touched back' by the recipient. This connection provides the opportunity for feedback for both parties and the powerful potential for enhancing the relationship between osteopath and patient.

Students and osteopaths both explored and described the 'intent' prior to any physical interaction with a patient. This was undertaken cognitively and then developed using dialogue with the patient in preparation for touch. This ongoing dialogue between osteopath and patient appears to enhance the initial use of touch and seems to enable trust to grow. The importance of verbal and physical communication in healthcare is evident in other spheres. Brown et al. (2011) describe how the impact of touch conveys a deep physical presentation that was seen to be enhanced through both verbal and non-verbal communication and visual actions and gestures. The physical interaction provides a powerful basis for the formation of trust. This is echoed in my own research where touch is a powerful mediating tool to affect the formation and development of trust between osteopath and patient and plays a powerful role in mediating relationships through the consultation. Osteopaths and students

described how touch worked as a method of communication, sometimes prompting deeper aspects to be conveyed as a closer form of communication. They described difficult conversations with patients who had communicated information, seemingly prompted by the effects of touch. This indicates a level of expertise at managing this which has implications for education. The complex effects of touch are still not entirely clear within the osteopathic professional interaction (Consedine et al., 2016) and how these truly mediate the interaction between osteopath and patient and the impact they have on the formation of professional trust require deeper exploration in future research.

Alongside the intent prior to undertaking touch is the awareness of consent, both from a regulatory viewpoint required throughout the consultation and particularly prior to touch. Osteopaths and students were aware of the requirements for consent and discussed this component. They evidenced awareness of recent legal changes (United Kingdom Supreme Court, 2015) regarding the Supreme Court ruling in the Montgomery case as discussed in Chapter 5 and were able to cite the implications for gaining consent within the context of the consultation. They were keenly aware of the need to prepare patients for touch and the need for this to be individual and tailored to each one. Students also showed awareness of consent as a continual process throughout the consultation and the ability to use it within the dialogue with patients. Patients in this study, described consent as part of a discussion rather than as a perceived formal process. This may be due to the delivery of consent, included within a dialogue rather than as an individual focus in and of itself. The subtle difference in perception between a formal requirement and a fluid discussion within a dialogue about care appears to be part of the call for patient-centred care and autonomy in decision-making.

Alongside the need for consent, the ability to provide competent clinical care was acknowledged by all participants in this study. Van de Camp et al. (2004) state that professional trust is strongly linked to professional standards and regulatory frameworks in the sense that competent healthcare practice requires a public trust that practitioners are meeting standards. Swick (2000) describes professional competence as an obligation not only towards the individual patient and public, but also on a profession-wide basis (Swick, 2000). The Osteopathic

Practice Standards (General Osteopathic Council, 2012) have recently undergone profession-wide consultation in preparation for renewal and updating. I have contributed to this debate and the new standards (General Osteopathic Council, 2018) will come into force in Autumn 2019. The previous iteration of the standards mentioned the word 'trust' 7 times while the new updated version now mentions 'trust' 13 times, although these relate to similar areas and sections. However, the increase in frequency of reference to the word, trust, is interesting in that the profession may be becoming more aware of this important component within the osteopathic consultation.

An important component in osteopathic practice appears to be the time allowed for the patient consultation. Participants in this research acknowledged and valued the consultation length in enabling time for the patient to talk and discuss their problems, for the osteopath to be able to take a holistic approach and for effective relationships to form. Waters et al. (2016) discovered that time was important to levels of patient satisfaction in the sense of waiting time for an appointment and length of contact time with a practitioner. They reported that patients did not want to feel rushed and wanted time to get a response from the practitioner in terms of empathy and compassion. This implies that the affective nature of the interaction is as important as the clinical aspects. In alternative medicine, Pedersen et al. (2016) describe how the holistic nature of practice often incorporates a greater length of consultation time in order to explore patients' presenting complaints and background information than is sometimes possible in conventional medicine. In my research, all participants valued the length of the osteopathic consultation for the ability it provided to engage in dialogue and use touch to examine and treat in a holistic manner and this appears to promote engagement on both sides and the building of trust. The length of time also appears to have a profound effect on the building of trust and this is mentioned in many studies (Waters et al., 2016; Mechanic and Meyer, 2000). Rørtveit et al. (2015) describe time as underpinning the ability of nurses to demonstrate multiple affective skills in the development of trust and this is echoed in my research.

Van Mook et al. (2009) describe trust not as an inherent right of the professional but as needing to be deserved and earned from the public by providing good

care and meeting the patients' needs. Trust is therefore part of the altruistic nature of the healthcare professional by putting someone else's needs ahead of your own. Osteopathy as a private healthcare practice requires patients to initially source the practitioner and pay for the consultations which can affect their expectations and creates a power imbalance between parties. The importance of the patient as a consumer in the healthcare market potentially means they are in a vulnerable position (Clark, 2002) as they are in need of help, often in pain and exposing themselves to the practitioner's judgement and skills. The reasons for patients seeking alternative healthcare are also important as they are powerful stimuli and can have an effect on the new therapeutic encounter through patients' expectations and hopes of a successful outcome. Van den Brink-Muinen and Rijken (2006) claim that there is a perceived growing disillusionment with allopathic healthcare where patients seek alternative treatments and this is particularly common for chronic conditions, for example musculoskeletal conditions, pain, migraine, and rheumatoid arthritis. They discovered that patients perceived alternative therapy practitioners would listen to them, take a holistic view and wanted a more active role in deciding on their treatment. Bowman (2013) claims that effective communication skills enhance the building of trust and this appears to be evident in my own research where patients have talked about the value they place on building deep therapeutic relationships with osteopaths which develop over time and are rich and meaningful.

Participants in this research expressed the importance of the developing relationship between osteopath and patient. The rationale for my exploration of professionalism within osteopathy included a sense I had that there was a unique component to the professional practice within the osteopathic sphere due to the increased time we spend with patients which enables close relationships and the building of a partnership with them. Previous research has shown that trust is strongly found in situations where cooperation exists, and this can lead to positive therapeutic outcomes within interactive, engaged environments (Goudge and Gilson, 2005). Wilk and Platt (2016) claim that promoting patient centred care through sharing decisions and enhancing a focus on health promote trust. The aspect of patient partnership and empowerment within my own research strongly resonates with this in promoting



a patient-centred approach and nurturing the working-together between osteopath and patient, particularly in terms of creating a 'dialogue' and empowering patients to take responsibility for their own health. Osteopaths, students and patients described cooperation and working together for a shared, facilitated outcome and the aspect of time also appears to enable the development of this and the ability to adapt and customise the approach taken to each individual.

Trust appears to be strongly contextually dependent in the sense that it is specific to individual relationships, but also affected by social and cultural aspects which make it more difficult to define due to these layered facets (Wilk and Platt, 2016). Van Mook et al. (2009) discuss how continual social change requires professionalism and professional trust to develop and adapt and for practitioners to be fluid and flexible in being responsive to this. Professionalism also appears to be reliant on practitioners maintaining and expressing deep morals and core values (Brown and Ferrill, 2009). This very strongly links to my own research in that the interpersonal skills enhanced by increased consultation time allowing listening, hearing, communication, dialogue, touch, and patient involvement in their own care are paramount. My research has shown that the concept of professional trust in osteopathy is constituted of a wide range of components from the authenticity of the practitioner through how they interact with patients via dialogue and touch in building relationships, showing compassion and being non-judgemental, reflecting on the process, adapting to meet the individual patient's needs and creating a successful partnership. These facets are enabled by the osteopathic practitioner's ability to control their practice (for example appointment length, availability, style of practice) leading to the ability to develop and nurture trust in osteopathic practice.

*Research Question 2: Is there a consensus of osteopathic professionalism amongst all stakeholders in the osteopathic remit?*

There was a consensus of opinion amongst all stakeholders within this research. Osteopaths, students and patients all valued the osteopath/patient interaction and had significantly similar understandings of the necessary

components of professional trust in osteopathy. No participant was able to discuss all the aspects in one session, but amongst the interviews and focus groups they were able to explore these in the context of the osteopathic consultation process, taking into account the process from first meeting through to the developed educational outcome at the end of the process. There were no areas of dissension within the discussions which was encouraging although there were varying levels of conceptual understanding, for example students understandably showed less finesse in understanding the fluidity of managing the many facets of professional practice and patients did not have the same perceptions of regulatory issues. The fact that osteopaths and students all act as models for peers to work and practice on during the educational training, appeared to enable them to have a view of practice from the patient's perspective, but they also evidenced a solid understanding of patients' needs which was demonstrated by their thoughtful contributions to the research. Patients provided insightful opinion and participated equally fully appearing similarly able to discuss all aspects. There appeared to be insights gained during the research, for example where participants developed greater understanding of concepts through the discussion:

*... that's actually very different, isn't it? From, we've probably because of our interaction because of the time we've got with the patient - physical examinations we do, our sense of touch - they're probably more receptive to hearing things from a GP that would probably get their back up, isn't it? I've never really thought of that actually until now.*  
(Finlay, osteopath focus group 21/5/17).

*...one thing that came out when we did our group - it had never occurred to me, being entirely selfish I suppose, that the minute you see someone, they're formulating in their mind while they're talking to you, what they're going to do to you and how they're going to treat you. We have this expectation that you will instantly know and you'll crack on and do it. It never occurred to me, you know, the brain's turning and you're thinking 'right what's the best way, what do I do for this?'.*  
(Maureen, patient, final focus group 25/11/17)

The 'extra' values which emerged from the pilot study, (being reflective, empathy, humility and advocacy), appeared to be largely evident in stakeholders' perceptions of professionalism with the exception of 'advocacy'. This did not appear to be understood as a stand-alone concept when drawn into the discussions. Stakeholders did not appear to perceive this as an important constituent of osteopathic practice and many asked for clarification on the definition. Osteopaths discussed advocacy within the patient care remit, for example referring patients to other healthcare practitioners when required and providing professional support in doing so. Osteopaths and students all discussed supporting and educating patients in optimising their health and wellbeing. Patients did not evidence a strong opinion on advocacy from the osteopath other than by the practitioner having their best interests at heart. Patients had not considered the extra value of self-reflection, but in discussion valued it in terms of an osteopath developing and improving their practice and level of care. However, osteopaths and students all appeared to feel that self-reflection was an inherent part of practice and necessary to the successful patient encounter. This has important implications for the teaching and learning of professionalism and enhancing the formation of professional trust which will be discussed later in this Chapter.

*Research Question 3: How does an osteopathic theory of professionalism compare with those of other healthcare modalities?*

There are similarities between components of professional trust in osteopathy and those within other healthcare spheres. The major underpinning factors found in recent definitions of professionalism in healthcare (American Board of Internal Medicine, 2002) are equally prevalent in the findings of this research and evident within the osteopathic remit. The components of professionalism are manifest in medical regulatory guidelines which are shared across professional spheres and evident in both the existing and updated Osteopathic Practice Standards (General Osteopathic Council, 2018, 2012).

This research has provided a subtle difference which appears key to the osteopathic sphere and this relates to how professional trust is formed and enhanced by the two elements of dialogue and touch. These appear to be

important to the whole interaction and create and shape the interaction and the formation of professional trust. While these aspects are noted and discussed by researchers elsewhere, they have not been combined together within an understanding of professional trust, neither have they been related to osteopathy. Other aspects that are particular to osteopathy, such as the ability to provide longer consultation times, enables the osteopath to spend more time with patients facilitating in-depth exploration and discussion, and the building of a partnership which leads to empowerment and the opportunity to educate patients about their health. The dialogue that forms between osteopath and patient pervades all these areas and enhances the development of all the facets. The use of touch early on in the interaction and which continues through the consultation, is essential in many subtle ways, both in evaluating and treating but in connecting with the patient on a number of different emotional and interpersonal levels. These factors appear to be more evident and more strongly nuanced in this research and within osteopathic practice.

*Research question 4: How can the theory of professionalism be taught to osteopathic students?*

The findings from this research have indicated that there are many opportunities for advancing knowledge and skills in developing professional trust in osteopathy. Current osteopathic educational curricula contain many of these components, yet learning through training with textbooks and lectures can appear insufficient in preparing students or novice practitioners for the diversity of clinical practice, and it is unlikely that those tools alone will be sufficient in teaching students the skills and capabilities which are so nuanced for capturing professional trust. However incorporating learning through active participation may be a valuable tool to aid learning (Monrouxe et al., 2011). In my own research students have shown great understanding and awareness of the constructs of professional trust but as a skill to be learnt there may be further learning opportunities from understanding more fully what patients expect. Exploring these and understanding the skills that are required may help to improve their knowledge and abilities. This will be discussed further in the section discussing implications for research practice.

The attributes for professional trust appear to be both person and role specific and most importantly these appear to be absorbed within the consultation process not as stand-alone elements, but as fluid, evolving components. It does not seem to be sufficient to evidence these in isolation but as an active and fluid enterprise which is context and patient specific. The calls in previous research for these to be evidenced more focally (Brown and Ferrill, 2009; Jha et al., 2006) seem to me a requirement to decontextualise them outside of the remit in which they occur. These attributes for professionalism are not only multiple, they require undertaking intuitively as required (Dall'Alba and Sandberg, 2006) and each practitioner will place their own interpretation on their use and timeliness individually in the workplace (Billett, 2001).

It is my belief that the search for a fixed criteria for professionalism or professional trust is unlikely to be achieved without the context or vitality of the environment in which they happen. The nuances within this theory of professional trust in osteopathy indicate that there are likely to be unique facets to professional trust within individual healthcare specialties which need acknowledgement and development. These nuanced understandings will need to change and mature as social, legal and regulatory changes occur and will require the input from all stakeholders in a dialogue to continually develop understanding and best practice.

This is important for the teaching of professionalism as the constructs are likely to be context specific, but also they are not stand-alone concepts but intrinsic to the active environment of clinical practice (Arnold, 2002) and require to be learnt in context and in vitro in professional life. How professionalism is enacted in practice is the most valuable learning tool, hence, in my opinion, the requirement for students to explore their growing understanding of professionalism in the teaching clinic is paramount. I agree that this is required from the earliest possible stages of training (Schafheutle et al., 2012) to enable students to develop reflective abilities to make sense of their experiences (Monrouxe et al., 2011) and to develop the ability to link theory to practice (Keeling and Templeman, 2013). This development of understanding of professionalism is not just required by students, but by increasingly experienced practitioners who continue to learn throughout their professional life. But it also

requires a dialogue with patients who also learn from their authentic experiences in the osteopathic consulting room. The requirement for professionalism is not just for the patients' sake – it is also essential for learners and practitioners (Wagner et al., 2007).

#### The PIECE learning cycle to build professional trust in osteopathy

In order to enhance the teaching and learning of professionalism with a view to increasing understanding of professional trust, I have developed a learning cycle with suggestions for tools that educators might use in order to teach students the facets of professional trust more effectively and to support students' learning of this complex construct (Figure 7, p.138). The PIECE learning cycle to build professional trust in osteopathy contains in the themed 'coloured' boxes the key skill criteria required at each stage based on the themes uncovered in this research. I have provided in the grey boxes suggestions for how these skills may be taught and learnt, although these suggestions are not exhaustive. Previous research has concurred that self-reflection and discussion are some of the most effective teaching and learning tools for professionalism (Santen and Hemphill, 2011; Passi et al., 2010) and I agree with this from my experience as a clinical educator and from my own learning through practice. Self-reflection on practice has been described as the driving force for change enabling practitioners to question their abilities and previous actions providing a route to developing personal and professional growth (Gaiser, 2009). It is important that this self-reflection is reported to faculty or peers for feedback, discussion and guidance. It is the conclusions and outcomes of the self-reflection process which enable a practitioner to develop an understanding of, and development on, practice which requires not only reflection, but discussion with others.

Group discussion, either with peers or faculty, is another effective means of learning with and from others and this can be useful for case-based discussion or utilising vignettes. Much research has shown that group discussion of clinically relevant cases facilitates learning (Gaiser, 2009; Hilton and Slotnick, 2005), particularly as it relates to the nature of situational learning in context (Gaiser, 2009). Previous research has shown how vignettes have been useful in research into professionalism (Bernabeo et al., 2013; Boenink et al., 2005).

The use of video vignettes in my research enabled participants to view contextual facets (for example attire, environment, facial expressions and tone of voice) which were valuable in providing extra nuances to aid participant reflection and engagement:

*My opinion is, just even the background is unprofessional - it looks like someone's house and I know if you're working from home inevitably it's still your home.... but, I haven't done it but when I do my practice it's going to look very much more like a clinic, a friendly clinic. Wearing a stripey top with buttons and a pink edging too - is unprofessional.*

(Finlay, osteopath, interview 5/2/17)

*I think he's probably a natural-born complainer - that's, that's the feeling that I get from him. More, sort of, his glass is half empty than half full. That's my impression.*

(Agatha, patient, interview 17/2/17)

These factors were particularly effective in providing additional detail and nuance to the video vignette scenarios, providing participants with greater background information and emotional input in the way the actors portrayed the characters which I feel helped in stimulating discussion.

These subtle factors prompted participants to comment on aspects that would not have been present within a written paper vignette and allowed participants to explore aspects of practice that other tools may not have stimulated. Clinical practice is an active and sometimes unpredictable environment which contains factors stimulating all the senses and demanding a constantly reflexive approach. The power of the video vignette captures some of these features more fully and provides a greater sense of the clinical environment. The video vignette format is becoming more popular in research by using recorded patient interactions and provides a useful tool for enhancing the richness of information and distinct nuances (Bradbury-Jones et al., 2014) and I have found the video vignette approach particularly useful in this research. The potential for the video vignette as a teaching tool is still under-researched and I would like to explore its utility further within the osteopathic educational remit. This research

did not enable me to capture feedback on the video vignette tool I used, yet future research using developed video vignettes portraying practitioners', students' and patients' perceptions of osteopathic clinical practice would enable this.



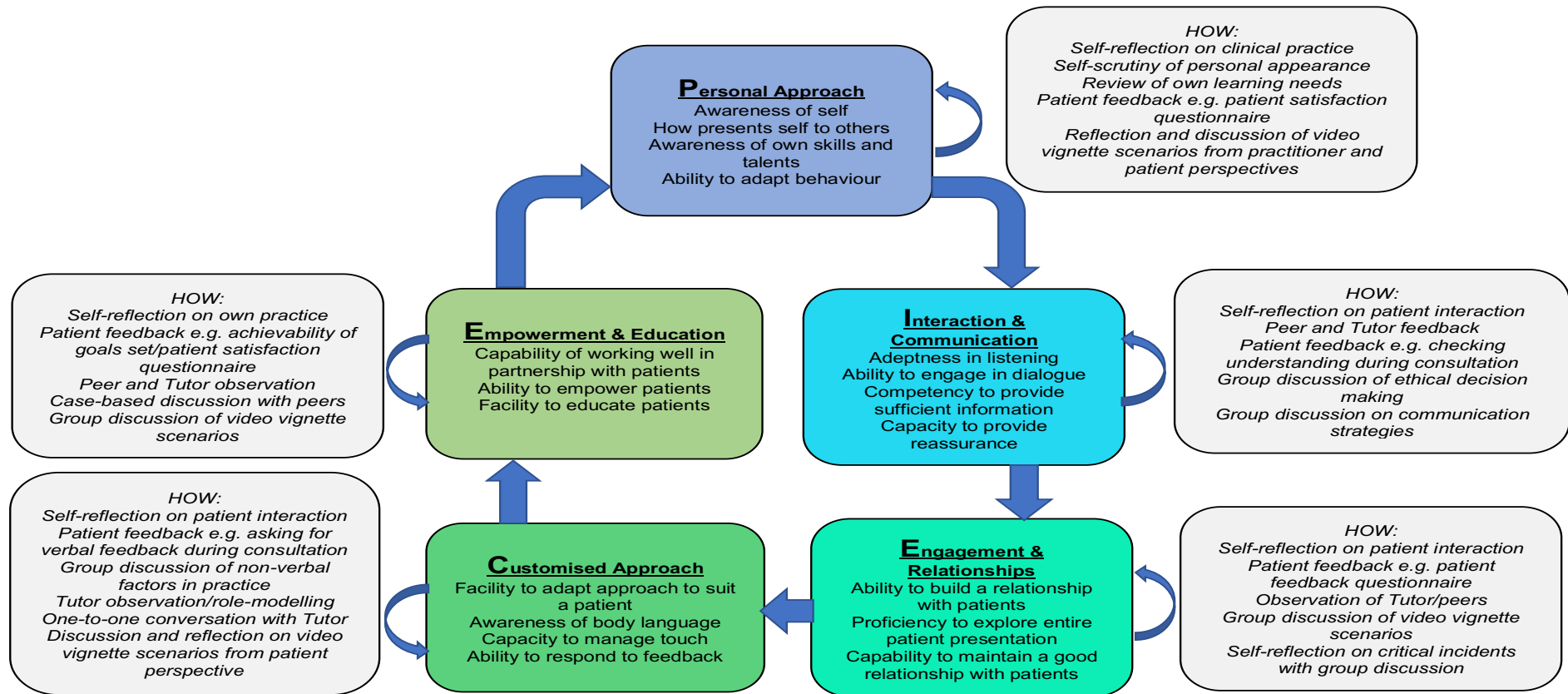


Figure 7 The PIECE learning cycle to build professional trust in osteopathy

### The PIECE self-reflection tool for students to learn about professional trust

I have also developed the PIECE self-reflection tool for students to learn about professional trust (Figure 8, p.141). This has been designed in sections to reflect the 5 themes developed in this research and is intended for use by students to reflect on their clinical interactions with patients in the teaching clinic. Each section provides self-reflection questions and tasks under the five themes of Personal approach; Interaction and dialogue; Engagement and relationships; Customised approach; Empowerment and education. It is not intended that students would attempt all the themes in one sitting, instead they would choose one of the themed areas each time, either chosen dependent on their particular learning needs, or at the suggestion of a Clinic Tutor. Students would need to report back to the Clinic Tutor on completion of the self-reflection activity to discuss their reflections and creation of strategies for learning from this and adapting their future practice. The reporting process could be incorporated into a small group session with fellow students to allow others to learn from and share knowledge and information. The tool can be used at any stage of the learning journey but may be more valuable to students who take active responsibility for patient care in their more senior years. Students can undertake reflections in similar areas and compare back to previous reflections to assess their learning journeys and compare or contrast effectiveness of learning strategies. In this way students can build up a resource of learning strategies based on their individual clinical experiences, explore their success in practice, share their knowledge and skills with others and develop effective skills to foster professional trust in clinical osteopathic practice to prepare them for entry into the profession and future autonomous practice.

I intend to adapt this self-reflection tool for qualified practitioners to use for continuing professional development. The framework for continuing professional development, alongside the Osteopathic Practice Standards, has been under review and a new professional development framework has recently come into force in the Autumn of 2018 (General Osteopathic Council, 2018c). The updated cycle has changed from an annual cycle with a requirement for 30 hours of further learning of which 15 hours had to involve learning with others. The cycle previously required self-reporting by each

individual osteopath with oversight by the regulator. The new CPD cycle has changed to a three-year cycle which now requires osteopaths to undertake learning across all themes of the Osteopathic Practice Standards. This must include one objective activity gaining feedback from either patients or peers, an activity relating to communication and consent, and the full cycle completes with a review discussion with a peer who is a healthcare practitioner. The PIECE self-reflection tool lends itself well to this new framework as practitioners who engage in self-reflection will be able to report on and discuss this activity with their peer reviewer. It can also be undertaken throughout the three-year period so there is regular engagement and discussion to enable feedback on practice and continual learning and adaptation of practice.

It is hoped that a greater awareness of the facets which contribute to the formation of professional trust and practitioners' insights into these, might support practitioners, both students and qualified osteopaths, in engaging with patients more effectively. By understanding what is important to patients, improving their skills in these key domains through reflection I hope practitioners may enhance their understanding of their practice and what is important to patients in the osteopathic encounter. This may, in its turn, potentially limit future complaints to the Regulating Body.

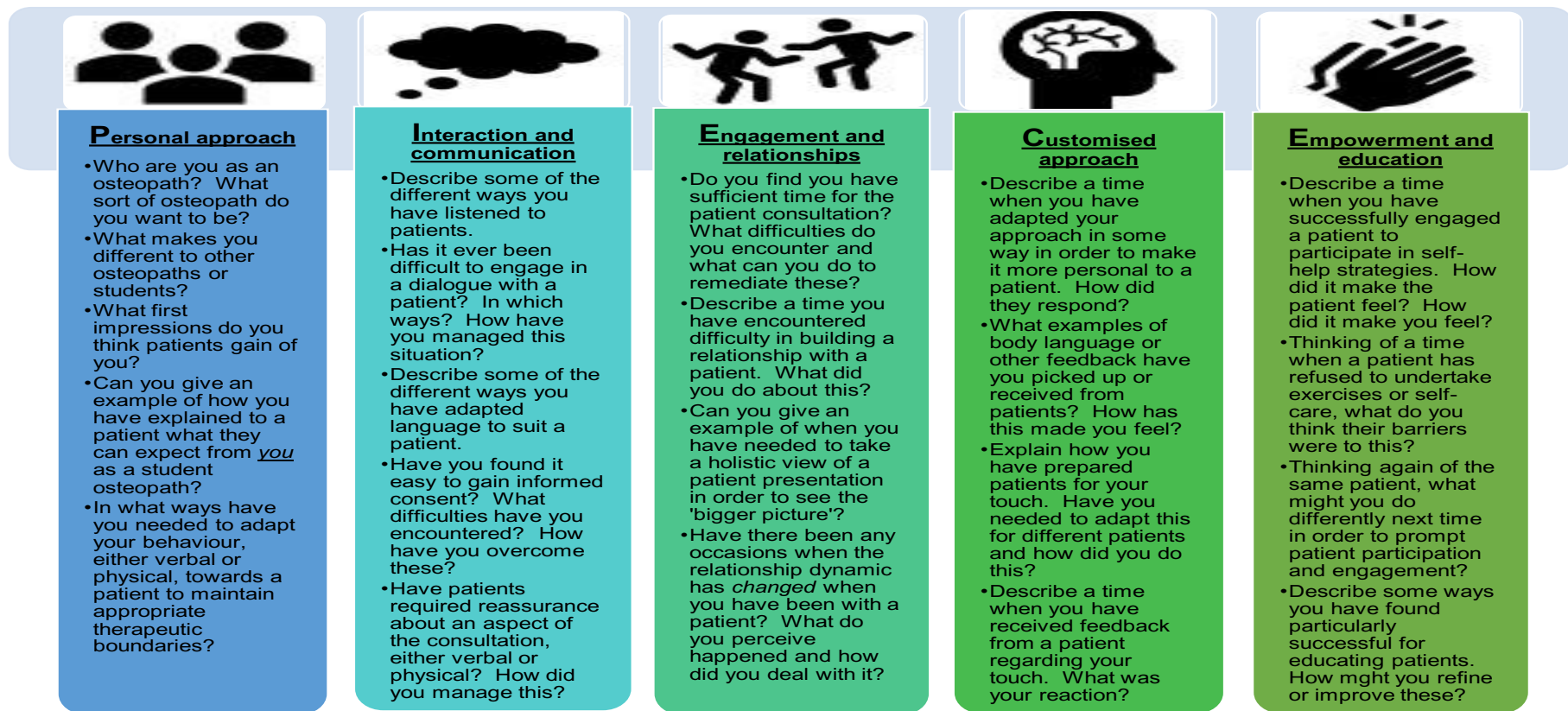


Figure 8 The PIECE model: self-reflection tool for students to learn about professional trust

## **Chapter 7 Conclusions**

This study set out to explore a theory of professionalism in osteopathy as this had not been undertaken previously and as an osteopath and osteopathic educator I felt it important to understand how this occurs in practice in order to better support teaching and learning. The research sought to uncover the perceptions of osteopaths, students and patients as to their concept of professionalism within osteopathy, to explore what this *means* in osteopathic practice, to compare whether this was similar to other healthcare models and importantly how this can be disseminated to the profession and taught to future osteopathic students.

My research uncovered a theory of professional trust which I have named the PIECE theory of professional trust using the acronym from the five key themes: **P**ersonal approach, **I**nteraction and dialogue, **E**ngagement and relationships; **C**ustomised approach; **E**mpowerment and education. These elements of osteopathic professional trust are bound together by the facilitative feature of a two-way dialogue and the powerful component of touch, combining to create a form of professional trust in the osteopathic consulting room. These elements of dialogue and touch are important to the osteopathic consultation where the hands-on approach is such a vital aspect of osteopathic treatment and which may make this element of 'trust' more specific to the osteopathic profession.

The findings indicate that there is a strong similarity to the professionalism present in other healthcare spheres in the sense that many components inherent in guidelines are shared across professional spheres and evident in both the existing and updated Osteopathic Practice Standards (General Osteopathic Council, 2018, 2012). The key differences which have emerged relate to the specific exploration of values and attitudes important to osteopaths, osteopathic students and osteopathic patients, how these relate intrinsically to osteopathic practice and how the element of trust has been exposed and is presented within this remit. The combined components of dialogue and touch used in the participatory process have emerged more focally in the osteopathic

remit. The fact that osteopaths are able to spend more time with patients enables the dialogue to develop which leads to a clear empowering and educational process. This is evidently welcomed and appreciated by all stakeholders. The element of touch has also proved to be important in my research as osteopaths use their hands early on in the consultation and this facet not only contributes to beneficial therapeutic outcomes but also mediates the entire consultation process by providing a palpatory dialogue which contains expression, comfort, reassurance and learning for the osteopath but also the patient in the sense that they are learning about their own bodies.

An important implication of these findings is that the values and attitudes prevalent are not stand-alone concepts but learnt, enhanced and enacted within the clinical teaching context. It provides a sense of the increasing value for professionalism to be learnt in vitro; both in the teaching clinic for students but as a continuing process in the consulting room for practitioners. It provides an understanding of the fluid, interconnecting components of the osteopathic consultation in which professional trust is formed and developed which should aid teaching and learning in undergraduate osteopathic educational institutions and as a component of continuing professional development for qualified practitioners. This enactment of professionalism in practice is potentially the most valuable learning tool, not only for students but for clinicians throughout their working lives. This study has also explored the perceptions of patients who too are learners within this environment through their experiences and interactions with osteopathic practitioners. The requirement for a greater understanding of professionalism is therefore essential for all participants: practitioners, students and patients alike.

#### Implications for education

The PIECE theory of professional trust in osteopathy may increase awareness of the factors that contribute to the development of trust in the osteopathic consultation and be useful to all stakeholders, but particularly to osteopathic educators, students on their learning journey and osteopaths in practice as part of their continuing professional development. Practitioners can explore the individual components, relate them to their own practice, learn from their self-reflection and adapt their practice to encapsulate these more effectively.

The PIECE learning cycle to build professional trust in osteopathy provides suggestions for educational tools that can be used to teach students the facets of professional trust and is designed to support students' learning of this complex construct more effectively by enabling educators to tailor teaching and learning to key areas. The teaching and learning tools within the learning cycle are all intended to provide formative feedback to enhance learning and the development of skills.

The PIECE self-reflection tool for students to learn about professional trust in osteopathy is designed in sections to reflect the five themes developed in this research and is intended for use by students to reflect on their clinical interactions with patients in the teaching clinic. It is hoped that the learning cycle and reflection tool will be useful for both educators, osteopaths and students in advancing their knowledge and skills in these areas through formative feedback and regular self-reflection.

The consideration of the 'touch' aspect in the development of professional trust in osteopathy needs further research, not only to understand it within this context in more detail but to inform teaching and learning of it for both practitioners and students on their learning journey. It would be invaluable to explore this component in the hands-on therapeutic encounter between practitioner and patient in building professional trust. Educators would benefit by considering further the element of touch within the curriculum, both in the early stages when educating student osteopaths to use their hands to evaluate, diagnose and treat but to also take into account in greater detail the feedback elements gained from interaction via touch. Elements of the PIECE model self-reflection tool may be useful in enabling students to gain verbal feedback from patients to support their learning and these can help enhance reflection on practice in the clinical environment. These could also be drawn into the classroom for discussion and used for developing sessions for adapting touch. In this way, the formal learning in the classroom could be combined more fluidly with the in-vitro learning of the teaching clinic to streamline the learning from one to another and enhancing the awareness of how touch can mediate the interaction between practitioner and patient. I believe that professionalism

needs to be taught both formally and informally, that it needs embedding more explicitly within all areas of the curriculum and that it also needs to feed actively throughout the learning journey within and across modules and teaching environments. In this way it will not be learnt as a stand-alone action in individual areas but taught organically across all modules so that it spreads into all aspects of the curriculum and becomes embedded as a mantra in all areas of practice.

The implications for summative assessment of students' ability to generate professional trust in osteopathy indicate that the teaching clinic is the key environment in which this should occur. The facets of professional trust are active and organic, undertaken in vitro in the osteopathic consultation with patients and therefore I believe assessment should be undertaken in this remit too. The criteria contained within the PIECE learning cycle to build professional trust in osteopathy could be used to create a stand-alone tool, but if not embedded within the nuanced aspect of clinical practice it risks the same problems as researchers have found before of students professing behaviour in an assessment situation that is not their usual conduct (Shapiro et al., 2015; Rees and Knight, 2007). It is unlikely that assessment can be as useful through using case-based scenarios, written or video vignettes or standardised patients. These are important tools for building the skills through reflection and group discussion, but the intrinsic facets of professional trust require the dynamic interaction with a patient in the unpredictable environment of clinical practice. This allows observation of students' skills in-vitro, particularly in the area of the 'Customised approach', where fluid adaptation, intuition and monitoring of the physical interaction occur. These are subtle but vital aspects which can only occur when actively engaged in practice (Martimianakis et al., 2009) and which develop over substantial periods of time (Hilton and Slotnick, 2005) and therefore continuous assessment is best placed to observe and assess these specialised growing skills.

The problem of assessing through continuous observation can be mitigated to some degree by incorporating feedback sessions alongside the observation in order to explore a student's reasoning behind, and awareness of, their individual clinical practice. Aspects of the self-reflection tool could be



incorporated to explore a student's understanding of their practice in this format to enable faculty to assess the level to which they are achieving the skills and abilities of building professional trust assessed by summative clinical reports.

#### Implications for recruitment

This research was partly prompted by my concern as to whether osteopathic students who demonstrate a lack of professionalism can remediate effectively and I had felt frustrated by the lack of effective teaching and learning tools available to aid this. Picking up on unprofessional behaviour at an early stage provides the opportunity to effect positive remedial change and to develop improved understanding and enhanced skills. I hope the outcome from this research may help inform strategies to aid recruitment of students who express the capacity for professional behaviour at the outset.

Students bring inherent beliefs and values to the profession, some of which remain while others change. Professionalism appears to be a standard that is expected of the osteopath within the arena of professional practice but is also very personal to the practitioner:

*But I think that professionalism is a very individual choice matter and it depends to how, who you want to be, what you want to do and how, how you sleep at night. That's what I think.*

(Sally, student, interview 14/2/17)

This research has also shown that the idea of professionalism as an individual and personal component is also perceived by patients:

*...it's so many different things to different people. It's not one thing to everybody - it's many things to, you know, one person.*

(Maureen, patient, interview 31/3/17)

In view of this, I hope the PIECE theory of professional trust in osteopathy may help to aid recruitment by unveiling key attributes that can be incorporated into interview tools. Exploring the values of potential students may help to show their potential for developing into the osteopaths of the future.

### Implications for dissemination

A review of the Osteopathic Practice Standards has been ongoing during 2017-18 to which I have contributed. This review has now ended and the new draft Standards which have recently been published (General Osteopathic Council, 2018) will take effect in the Autumn of 2019, and I hope that at the next review stage the findings from this study could help inform further modification. The nuanced understanding of how professional trust is formed throughout varying stages of the osteopathic encounter could be used to develop a more practice-based explanation of the standards within the supporting guidelines and the elements of dialogue and touch could be incorporated and defined more comprehensively.

In my role working at an osteopathic educational institution and leading the clinical education within the teaching clinic I am well placed to introduce the learning cycle and self-reflection tools to enhance the teaching and learning processes. I intend to present my findings to the clinic tutors and osteopathic teaching staff and provide training to enable them to incorporate appropriate teaching tools to facilitate teaching and learning of professional trust in osteopathy. This is likely to require the development of resources to support these endeavours and I intend to build a reserve of video vignettes, practice-based case scenarios for group discussion alongside clear written guidelines for the self-reflection tool to enable educators to utilise these effectively and for students to gain the best results from their use. I aim to schedule a feedback session with teaching staff after the first term of their use to capture feedback on their utility, gain suggestions for adaptation or improvements and also to capture student feedback using an online questionnaire to ensure that their input is gained. I hope that this will enable me to hear the voices of all educational participants and enable an organic development of these tools.

I hope to develop a self-reflection tool for osteopaths based on the one already written for students but adapted to explore the more experienced practitioner. For example, question one in the section 'Personal approach' would not ask an experienced osteopath what sort of osteopath they want to be. A more suitable question might be "what facets of your particular osteopathic approach do you

value? Do you have any evidence that patients share these?”. Further items in the student tool will require similar adaptation to develop more nuanced questions suitable for the experienced osteopath. The aim of the developed tool will be to direct practitioners to self-reflect on the key areas that encompass professional trust in osteopathy and engage osteopaths to explore their current skills and abilities within these areas, not only by reflecting on their perceptions of their own abilities but by prompting them to reflect on feedback, either direct or indirect, from patients. This will then provide practitioners with a rich resource to discuss with other healthcare practitioners, but certainly with their peer reviewer at the end of the new continuing professional development cycle. This evolved discussion, based on evidence of their clinical practice, will allow them to unpick key facets of their practice through self-reflection and increase their professional awareness of their interaction with patients. I hope to provide this as a resource on the General Osteopathic Council continuing professional development website which already provides suggested tools and resources for osteopaths. I hope also to provide an article for the profession’s bi-monthly publication to reach all osteopaths in practice explaining the developed resource and providing a section containing likely questions and answers relating to its use for the continuing professional development cycle and how it may be undertaken. I hope to use colleagues as a resource for building this article by capturing their queries in order to develop as clear an explanation and presentation as possible. It is possible that this tool could be adapted and transferred to other healthcare professions and I would be interested in exploring this option.

I hope to publish articles from this research in the International Journal of Osteopathic Medicine outlining the PIECE theory of professional trust in osteopathy, the developed PIECE model educational tools for undergraduate education, the use of a PIECE model for osteopathic continuing professional development and the use of vignettes in osteopathic education. Publishing within the profession’s main journal would reach the osteopathic community and disseminate this knowledge to educators and practitioners in the United Kingdom, but I would be keen to publish abroad too in other osteopathic media. It is possible that the findings from this research could form a book that educators and practitioners could use to help enhance their practice. As

osteopathy is not within mainstream healthcare it would be valuable to collaborate with researchers in other healthcare spheres to explore areas connected to this research and widen the knowledge base. It is possible that this understanding of how professional trust appears to be formed in osteopathy may be transferable to other healthcare specialties where practitioners engage with patients through dialogue and touch. Exploring how these elements may be crucial in the forming of trust within other healthcare contexts might be beneficial in enhancing understanding of professional practice.

### Implications for research practice

The utilisation of unfacilitated focus groups was challenging yet interesting, although it did not appear to generate additional useful information beyond what was garnered from the facilitated ones and they merely served to reinforce information and opinion that had been evident prior to this. Participants' views and opinions appeared quite superficial and responses to the questions were not explored in any great depth and participants tended to agree with one another and move on to other discussions. The direction of the conversation was less focused and participants appeared to go off at tangents and then struggle to return to the original theme. It would appear that the lack of depth explored was due to the fact that no 'facilitator' was present to seek depth or clarification to responses. The lack of focus may have been due to my inexperience of preparing these, by not providing suitable questions for participants to explore or by not presenting participants with suitable prior instructions. It would be interesting to explore this in more detail to see whether this could be a useful tool in further research. My own impression from this research is that without facilitation of some type, participants are not prompted to explore depths of opinion and that the constituent balance of the group tends more to agreement rather than exploring dissensus. It seems unlikely that these are a useful tool to use in researching professionalism as the role of an osteopath, as facilitator, appears useful in managing the focus group process, however further research might uncover different results.

The video vignettes appeared extremely useful on a number of levels in providing the opportunity for stimulating wide-ranging discussion and providing prompts for the discussion. Their ability to utilise context specific scenarios,

incorporate problem solving opportunities and mimic critical incidents in practice was formed from experiences unique to practice and which formed provocative scenarios which were effective at stimulating discussion and debate. The visual and aural elements of the video vignette which provide extra content containing contextual and emotional stimuli appeared to be valuable in my research in provoking participants' reflection and discussion, as evidenced by Finlay and Agatha (Chapter 6, p.137). The use of video vignettes could therefore lead to potentially rich learning experiences for students and practitioners and could provide osteopaths and students with tools to inform and engage their learning and improve practice at all levels. The opportunity for providing a wide variety of contexts, encompassing multiple perspectives and in a variety of styles could be further explored in future research to see how they could be expanded and enhanced as an educational tool. Their usefulness in providing rich and detailed information in themselves, as well as providing themes for further discussion in the group settings, could be useful in teaching and learning about professionalism.

Participants actually appeared to gain benefit from participating in the research in terms of exploring their own understanding of professionalism, engaging and learning with others in the focus groups and discovering new knowledge from this interaction. Participants appeared to appreciate the data checking process and positive comments were received:

*It was interesting reading back through and reliving the process. I found the discussion very insightful and thought provoking. A privilege to be part of it.*

(Email from Maureen, patient participant final focus group, 30/11/17)

*Thanks so much for including me in this, it was so interesting and challenging ..... am sure i could actually rattle on for hours on end about the things you brought up. def up for another interview if you need.*

(Email from Jane, student participant for interview, 18/3/17)

The data checking process served as a means of enabling participants to have equal ownership of their data, to allow them to reinforce their thoughts and opinions, refute any confusions and add further information if they wished.

It appears that opening up a dialogue surrounding the concept of professionalism is beneficial to all participants both in exploring their beliefs and values, but also in educating stakeholders on differing viewpoints, seen through the eyes of actors in vignettes but also in discussion between stakeholders. This is potentially a powerful tool that could be utilised in single or mixed participant groups or as an individual reflective tool. It was interesting that the final focus group, with mixed participants representing all three stakeholder groups, required a huge element of trust in order for those present to be able to speak freely and openly about osteopathic professionalism. This reinforces the importance of trust within interactions between osteopaths and patients in any format or sphere.

The patient voice has been acknowledged in research (Spencer et al., 2000), and there is huge scope for involving patients in future research. The patient voice has been hugely important in this research as it opened a window onto their perceptions of experiences of professional trust in osteopathy. Without their input this research could not have been fulfilled and the findings indicate that there are multiple areas of osteopathic clinical practice which are key to the development of professional trust. There are ethical considerations inherent in including patients in healthcare research, yet these can be protected and mediated to ensure that patients can participate safely and fully to provide an equal input into exploring and enhancing healthcare practice (Bleakley and Bligh, 2008).

It has been stated that patients are an underused resource in research, particularly research into professionalism (Wiggins et al., 2009) and that patients could be equal partners in future research (Bleakley and Bligh, 2008). I agree with this as I feel the patient voice is critically important in any research within healthcare and my own research has benefited hugely from their participation. This could be developed further by including patients as equal participants in future research and fully valuing their role and input into

exploring aspects of osteopathic practice. Patients who participated in my research stated they found it interesting and educational, not only from exploring the subject of professionalism but by looking through the window of the osteopath's perspective. This ability to share experiences, perceptions and viewpoints is a powerful research tool to stimulate discussion. My choice of Constructivist Grounded Theory was well fitted to this opportunity as it allowed participants to explore others' views while prompting exploration of opinions, experiences and beliefs to build knowledge. The patient vignette that I wrote to be used for the interviews in this research was based on anecdotes I had heard over the years from patients and by being based on 'real life' experiences provided a gritty and compelling account. It appears vital for students and qualified practitioners to actually hear authentic accounts of patients' experiences so that they can reflect and learn from these. They could easily be incorporated into video vignettes to portray the information, expression of emotion and context which appear to be so valuable in prompting discussion and reflection.

Further research would be useful into the concept of what constitutes the 'safe space' that was mentioned in this research in order to ascertain what it means to patients and how it is created in the osteopathic consulting room.

Constructivist Grounded Theory might be a useful methodology for this in exploring osteopaths' and patients' perceptions as to how this is formed. This would enable a greater understanding of this facet which affects the ability for patients to open up to osteopathic practitioners and the subsequent interaction and relationship building that occurs thereafter.

### Limitations

This study was on a small scale and undertaken in one osteopathic educational institution and one osteopathic clinic, hence the transferability of these findings may be limited and expanding further research to a wider participant remit would be beneficial. The patients resourced were from my private practice and although some of the patient participants had experienced osteopathic interventions from other practitioners, some had not, therefore their perceptions were based on their experience with me. This limits the breadth of understanding in the osteopathic remit and would certainly need exploration

with a far greater range of patients. The study appears to have been the first to explore the remit of professionalism and professional trust in osteopathy and further research will be useful in investigating this in greater depth.

I undertook all the interviewing, ran the facilitated focus groups and analysed all the data myself. I shared and discussed my findings with my supervisors and maintained a reflexive journal throughout, however as a sole researcher it is possible that the findings were influenced by my preconceptions as an osteopath. I attempted to mitigate this as far as possible by sharing concerns with my supervisors, monitoring my level of reflexivity through the journal and demonstrating the construction of the theory with mindmaps and the use of participants' own words to enable their voices to shine through and be evidenced in the results of this research.

### Reflections

In the early stages of data collection in the main study I encountered recruitment problems and I suddenly realised that I had not fully taken on board the issues of power within this research project at the outset. I had felt such passion for the subject and keenness to create an understanding which would enable more focused and productive educational tools for students that I had presumed that others would share this excitement too. It was only when I had an initial poor response from osteopaths and students to participate that I fully realised what a difficult thing I was asking colleagues, students and patients to do: to talk about professionalism in osteopathy. I attach an excerpt from my reflexive journal detailing my realisation of this at Figure 9, p.154.

It appeared that after a couple of osteopaths and students were interviewed they discussed the experience with peers and requests to participate started to emerge. Students became very keen to participate, but osteopaths were less so and I only gained nine participants. This has involved me in much deeper reflection on how I should have approached participants, the need for greater reassurance or perhaps to have started with a focus group format which may have enabled participants to feel more comfortable in a group setting.



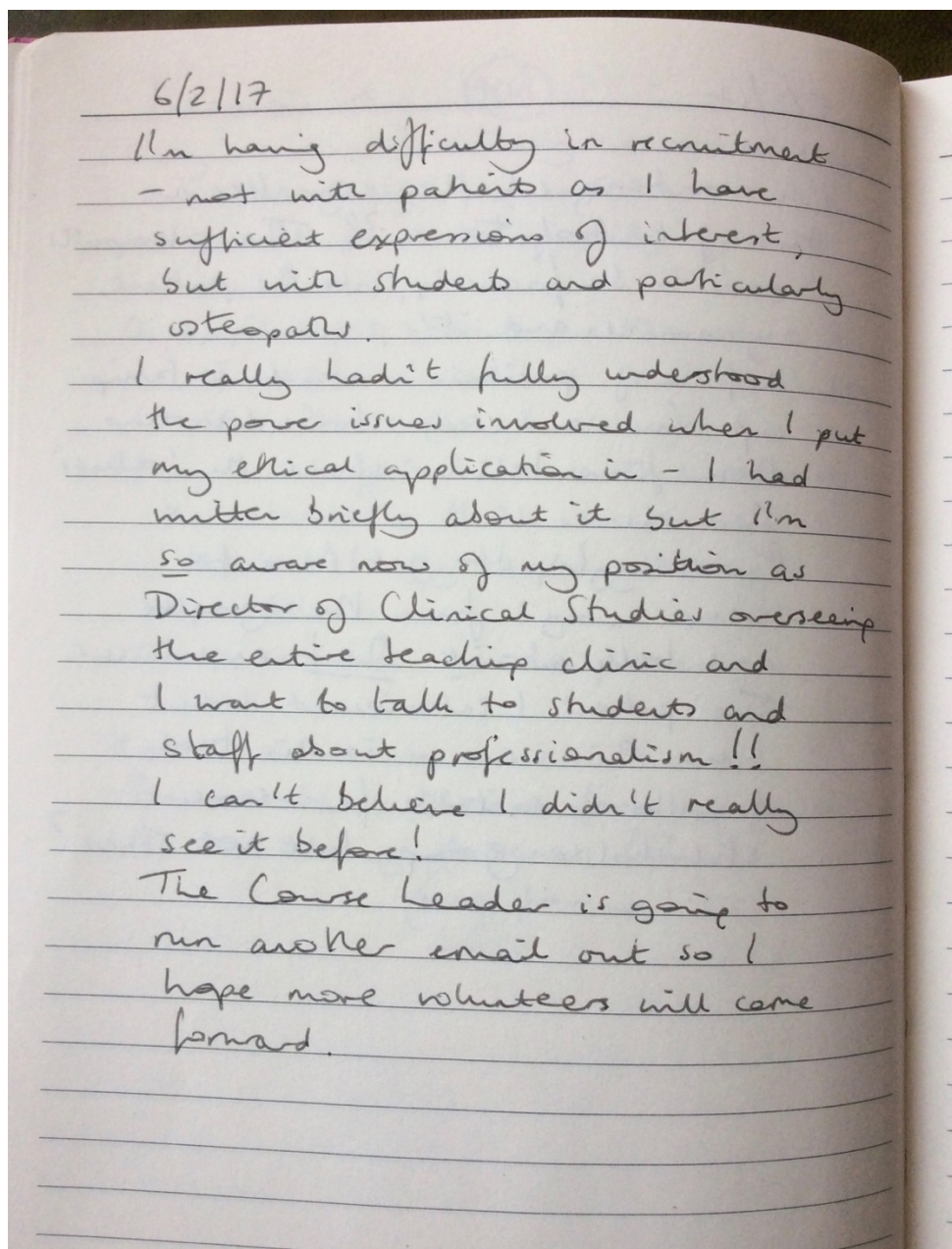


Figure 9 Reflexive diary entry 6/2/17

The data collection process spanned ten months, with periods of high intensity interviewing with long periods during which the data were analysed and then a burst of activity again when focus groups were run. This has had benefits and challenges in equal measure: the space between collection of data was useful in analysing previously gathered information and allowed reflection on what was found. At the same time it allowed attrition and lack of momentum in the process which meant that I seemingly lost focus at times, needed to repeatedly re-read the data/listen again to the recordings and redesign mindmaps in order to reawaken my positioning within the research.

As discussed in Chapter 3 it has been imperative throughout the main study to maintain awareness of my input into the process of data collection and analysis. I certainly sensed periods of discomfort during the research process in managing participant groups, exploring the data and I questioned my position in relation to the study. I believe that reflexivity is not a private, internal process but requires to be openly acknowledged and stated to allow for transparency and honesty. At times I struggled with my own pre-conceptions, while building understanding of concepts, yet trying to limit my own preconceived ideas by staying alert to my thoughts and exploring participants' perceptions. This was an onerous and challenging task which required a new method of learning about myself as a researcher within the research process. Managing my professional interactions with participants, both within the research process whilst maintaining relationships outside of this sphere, was challenging at times. It was a complex, woven set of relationships that needed constant exploration and review. At times I felt out of my comfort zone, daunted by the quantity of data collected and how to manage this. I sought refuge in Grounded Theory texts to find guidance as to how to proceed. I realised that researchers use various tools but that each research journey is personal and requires an individual approach, so I developed gradual confidence in managing the data through collating codes and themes using visual means. However, I have attempted to use participant voice by employing their own words and descriptions as much as possible so that my own voice does not deafen theirs. Using mindmaps created by these voices and the codes they produced, through the iterative process of developing themes through these visual methods, I have attempted to show the development of the theory. I believe I was aware throughout the data collection process of the issues of power and my own positioning both within and outside the research process. The undertaking of the unfacilitated focus groups really reinforced my awareness of this. Despite trying to be as passive a participant in the prior focus groups, my sense of anxiety during the first unfacilitated focus group as I was pacing up and down the corridor, brought to the surface my awareness of how 'in control' I had felt of the process previously. My anxiety was partly whether participants were comfortable with the process and were able to undertake it, as well as a concern as to whether it was going to produce useful data. I reflected on

whether I had been too involved with the facilitated focus groups in the sense of trying to direct them through questioning, but on reading back the transcripts and listening to the recordings I found that this was not so. It heightened my decision to try to be as passive in the final focus group as possible to ensure that stakeholders could fully provide their understanding and concepts in developing the final theory.

### Originality of the thesis

While a definition of professionalism has previously been created by the American Board of Internal Medicine Foundation (2002), there has been no conclusive definition of professionalism in healthcare in the United Kingdom. This thesis has been original in that it has explored professionalism within osteopathy which has not been undertaken before. I have also used video-vignettes which have not been used within individual interviews to prompt and stimulate discussion around the values and attitudes important to professionalism in osteopathy. I have incorporated both facilitated and unfacilitated focus groups to allow participants the freedom to speak with and without myself present as facilitator and to take into account some of the complex issues of power inherent in the study. I have involved patients as equal participants at every stage of the study to allow them equal voice within the generation of the theory.

### Summary

The PIECE model for professional trust in osteopathy has opened a window on a previously unresearched area of practice and has provided an understanding of how this occurs in the environment of the osteopathic clinical encounter. It has unravelled key elements which individually *matter* to osteopaths, students and patients, and when combined, build trust between participants and promotes an effective, strong, therapeutic intervention which is patient-centred. The model has uncovered the key facets of dialogue and touch which appear to be profoundly important to the osteopathic consultation and which provide an opportunity for osteopaths to advance their professional practice. The original PIECE learning cycle and self-reflection tool for students to learn about professional trust in osteopathy provide educators and learners with the

potential to develop their skills in building professional trust in osteopathy for the first time.

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## **Appendices**

### **Appendix 1**

#### **Combination of 'JBI QARI Critical Appraisal Checklist for Interpretive & Critical Research' and 'Quality in Qualitative Evaluation: A framework for assessing research evidence'**

Is there congruity between the stated philosophical perspective and the research methodology?

How defensible is the research design?

Is there congruity between the research methodology and the research question or objectives?

Is there discussion of a rationale for the study design?

Is there congruity between the research methodology and the methods used to collect data?

How well does the evaluation address the original aims/purpose?

How well defended is the sample/design/selection?

Is there a detailed profile/analysis of coverage/samples and discussion of this with the success of the data collection and methods?

Is there congruity between the research methodology and the representation and analysis of data?

Is there clarity of the basis of evaluation?

How well has the approach to/formulation of analysis been conveyed?

Is there congruity between the research methodology and the interpretation of results?

How credible are the findings?

Are the contexts of data sources retained and discussed?

Is the detail/depth/complexity (richness) of data conveyed?

Are there clear links between the data, interpretation and conclusions?

Is there a statement locating the researcher culturally or theoretically?

Are there clear assumptions/theoretical perspectives/values that shape/form the output of the evaluation?

Is there discussion/evidence of ideological perspectives/values/philosophies of the researcher and their impact on the methodological/substantive content?

Is the influence of the researcher on the research, and vice-versa, addressed?  
 Are there reflections on the impact of the researcher on the research process?  
 Are mechanisms in place to counteract the role of the researcher or mitigate for this?  
 Are other participants involved in the research process to assist the researcher?  
 Are participants, and their voices, adequately represented?  
 Is there evidence of diversity of perspective and has the content been explored?  
 Is the research ethical according to current criteria, or, for recent studies, and is there evidence of ethical approval by an appropriate body?  
 Is there evidence of attention to ethical issues?  
 Is there discussion of consent, confidentiality, and anonymity?  
 Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?  
 Is there scope for drawing wider inference and how well is this explained?  
 Is there discussion of strengths/weaknesses of data sources and methods?  
 Is there documentation of changes made to the design and reasons for these?  
 Is knowledge/understanding extended by the research?  
 Is there discussion of limitations and ideas for further research?

Joanna Briggs Institute (JBI) (2014a) '*JBI QARI Critical Appraisal Checklist for Interpretive and Critical Research*', Joanna Briggs Institute. [Online]. Available at [http://joannabriggs.org/assets/docs/jbc/operations/criticalAppraisalForms/JBC\\_Form\\_CritAp\\_IntCrit.pdf](http://joannabriggs.org/assets/docs/jbc/operations/criticalAppraisalForms/JBC_Form_CritAp_IntCrit.pdf). (Accessed 17th September 2015)

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## Appendix 2

### JBI Critical Appraisal Checklist for narrative, expert opinion & text

Is the source of the opinion clearly identified?

Does the source of the opinion have standing in the field of expertise?

Are the interests of patients/clients the central focus of the opinion?

Is the opinion's basis in logic/experience clearly argued?

Is the argument developed analytically?

Is there reference to the extant literature/evidence and any incongruency with it logically defended?

Is the opinion supported by peers?

Joanna Briggs Institute (JBI) (2014b) '*JBI Critical Appraisal Checklist for Narrative, Expert opinion and text*', Joanna Briggs Institute. [Online]. Available at

[http://joannabriggs.org/assets/docs/jbc/operations/criticalAppraisalForms/JBC\\_Form\\_CritAp\\_NarOpTxt.pdf](http://joannabriggs.org/assets/docs/jbc/operations/criticalAppraisalForms/JBC_Form_CritAp_NarOpTxt.pdf). (Accessed 17th September 2015).

### Appendix 3

Combined: ' JBI QARI Critical Appraisal Checklist for Interpretive & Critical Research' and ' Quality in Qualitative Evaluation: A Framework for assessing research evidence'

Author(s)	Paper	Year	Congruity between stated philosophical perspective and the research methodology	Congruity between research methodology and research question or objectives	Congruity between research methodology and methods used to collect data	Congruity between research methodology and representation and analysis of data	Congruity between research methodology and interpretation of results	Statement locating researcher culturally or theoretically	Influence of researcher on research addressed	Participants /voices adequately represented	Is research ethical and evidence of ethical approval	Conclusions drawn flow from analysis or interpretation of data	Knowledge/un derstanding extended by research
			<i>How defensible is research design?</i>	<i>Discussion of rationale for study design.</i>	<i>How well does evaluation address original aims/purpose?</i>	<i>Clarity of basis of evaluation.</i>	<i>How credible are the findings?</i>	<i>Clear assumptions/t heoretical perspectives/v alues that shape/form output of evaluation.</i>	<i>Reflections on impact of researcher on research process?</i>	<i>Diversity of perspective and content been explored?</i>	<i>Evidence of attention to ethical issues?</i>	<i>Scope for drawing wider inference - how well explained?</i>	<i>Limitations + further research</i>
					<i>How well defended is sample design/target selection?</i>	<i>How well has approach to/ formulation of analysis been conveyed?</i>	<i>Contexts of data sources retained and discussed?</i>	<i>Discussion/ evidence of ideological perspectives/v alues/ philosophies of researcher and impact on methodologica // substantive content.</i>	<i>Mechanisms in place to counteract the role of the researcher /mitigate for it.</i>		<i>Discussion of consent, confidentiality, anonymity ?</i>	<i>Discussion of strengths/wea knesses of data sources and methods?</i>	
					<i>Detailed profile/analysis of coverage/sam ples + discussion.</i>		<i>Detail/depth/c omplexity (richness) of data conveyed?</i>		<i>Other participants involved in the research process to assist researcher?</i>			<i>Documentatio n of changes made to design and reasons?</i>	
					<i>Discussion of success of data collection + methods.</i>		<i>Clear links between data, interpretation and conclusions?</i>						



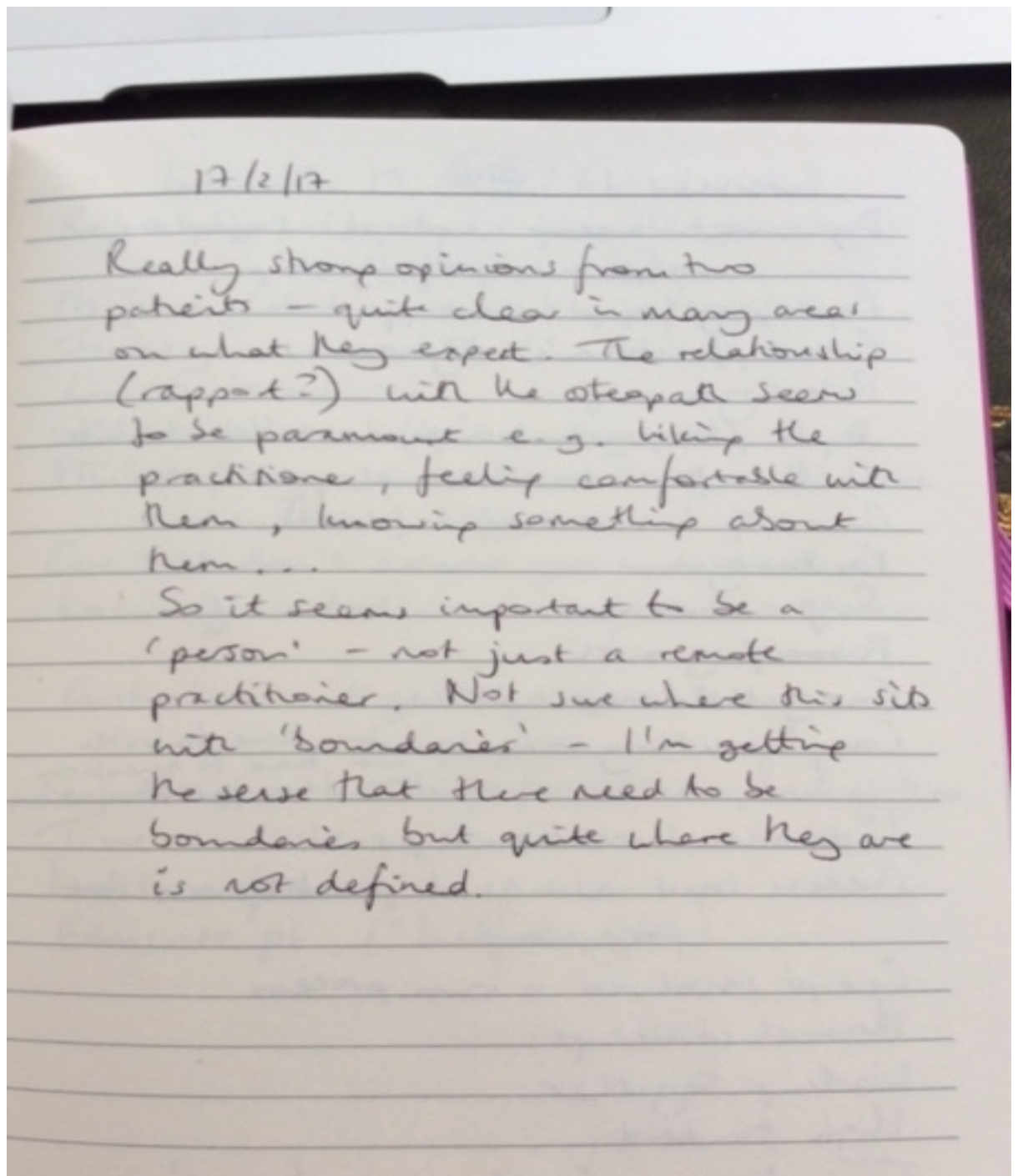
## Appendix 4

### Studies concerning professionalism in healthcare using Grounded Theory

Study	Classic GT	Straussian GT	Constructivist GT
Andersen 2008 <i>Determining competency for entry to Nursing practice: a grounded theory study</i>	✓		
Bernabeo et al. 2013 <i>The utility of vignettes to stimulate reflection on professionalism: theory and practice</i>			✓
Bryden et al. 2010 <i>Professing Professionalism: Are We Our Own Worst Enemy? Faculty Members' Experiences of Teaching and Evaluating Professionalism in Medical Education at One School</i>		✓	
Egnew and Wilson 2010 <i>Faculty and medical students' perceptions of teaching and learning about the doctor-patient relationship</i>		✓	
Finn et al. 2010 <i>'You're judged all the time!' Students' views on professionalism: a multicentre study</i>	✓		
Flynn 2007 <i>Nurses' perceptions of quality nursing care: a grounded theory study of overloading</i>	✓		
Gaufberg et al. 2010 <i>The Hidden Curriculum: What Can We Learn From Third-Year Medical Student Narrative Reflections?</i>		✓	
Ginsburg and Lingard 2011 <i>'Is that normal?' Pre-clerkship students' approaches to professional dilemmas</i>			✓
Jette et al. 2007 <i>Clinical Instructors' Perceptions of Behaviors That Comprise Entry-Level Clinical Performance in Physical Therapist Students: A Qualitative Study</i>	✓		
Park et al. 2010 <i>Observation, Reflection, and Reinforcement: Surgery Faculty Members' and Residents' Perceptions of How they Learned Professionalism</i>		✓	
Santen and Hemphill 2011 <i>A Window on Professionalism in the Emergency Department through Medical Student Narratives</i>	✓		
Scanlon et al. 2006 <i>Psychiatric nurses perceptions of the constituents of the therapeutic relationship: a grounded theory study</i>		✓	
Thompson et al. 2008 <i>Identifying Perceptions of Professionalism in Pharmacy Using a Four-Frame Leadership Model</i>		✓	
Thomson O 2013 <i>Clinical Decision Making and Therapeutic Approaches of Experienced Osteopaths</i>			✓

## Appendix 5

### Excerpts from Research Journal



Excerpt from research journal (17/2/17)

2/4/17

I'm really curious about the concept of partnerships. An osteopath said it is not partnerships but 'teamwork' due to the unequal balance of knowledge. What is the difference between the two?

This issue of power/hierarchy is interesting - there's a lot of talk about 'working together' - I need to explore how this works better.

Excerpt from research journal 2/4/17

## Appendix 6

### Questionnaire for Pilot Study

This research is investigating what osteopaths, osteopathic students and osteopathic patients perceive to be the values and attitudes of osteopaths.

Please provide one answer to each question below.

Are you (please choose only one)    Osteopath  
                                                          Osteopathic Student  
                                                          Osteopathic Patient

Please rate how important you

think each of the following values are in osteopaths by circling the number of importance:

Unimportant / Not very important / Important / Very important / Critically important ➤

1.	Accountability (to answer for their actions)	1	2	3	4	5
2.	Altruism (selflessness)	1	2	3	4	5
3.	Caring	1	2	3	4	5
4.	Commitment	1	2	3	4	5
5.	Communication	1	2	3	4	5
6.	Compassion	1	2	3	4	5
7.	Competence	1	2	3	4	5
8.	Working to the Osteopathic Practice Standards	1	2	3	4	5
9.	Excellence (professional)	1	2	3	4	5
10.	Having good relationships with other healthcare professionals	1	2	3	4	5
11.	Honesty	1	2	3	4	5
12.	Integrity (moral principles)	1	2	3	4	5
13.	Lifelong learning (keeping up to date with knowledge and skills)	1	2	3	4	5
14.	Listening to patients	1	2	3	4	5
15.	Respect	1	2	3	4	5
16.	Responsibility to patients	1	2	3	4	5
17.	Working as a team with other healthcare professionals	1	2	3	4	5
<b>Are there any further professional values you would hope/expect to find in an osteopath? Please list them here:_____ .</b>						

Please rate the following statements (circle *one* appropriate answer):

1. Osteopaths should give time to listen to patients.

Strongly disagree      Disagree      Agree      Strongly agree

2. Osteopaths should be prepared to justify their actions to patients.

Strongly disagree      Disagree      Agree      Strongly agree

3. Osteopaths should recognise the uniqueness of patients.

Strongly disagree      Disagree      Agree      Strongly agree

4. Osteopaths should be concerned about the welfare of their patients.

Strongly disagree      Disagree      Agree      Strongly agree

5. Osteopaths should be prepared to show leadership where required within their practice and in the profession.

Strongly disagree      Disagree      Agree      Strongly agree

6. Osteopaths should be dedicated to providing the best care they can for patients.

Strongly disagree      Disagree      Agree      Strongly agree

7. Osteopaths should continue professional learning throughout their career.

Strongly disagree      Disagree      Agree      Strongly agree

8. Patients should be involved in decision-making about their care.

Strongly disagree      Disagree      Agree      Strongly agree

9. Osteopaths should maintain continuity of care where possible.

Strongly disagree      Disagree      Agree      Strongly agree

10. Osteopaths should be sympathetic towards their patients wherever possible.

Strongly disagree      Disagree      Agree      Strongly agree

11. Osteopaths should be concerned about their patients' welfare.

Strongly disagree      Disagree      Agree      Strongly agree

12. A patient should be able to trust his/her osteopath.

Strongly disagree      Disagree      Agree      Strongly agree

13. Osteopaths should engage with other healthcare professionals as required.

Strongly disagree      Disagree      Agree      Strongly agree

14. Osteopaths should be able to make safe clinical decisions based on sound evidence.

Strongly disagree      Disagree      Agree      Strongly agree

15. Osteopaths should uphold moral behaviour and behave within the limits of the law.

Strongly disagree	Disagree	Agree	Strongly agree
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16. Osteopaths should be prepared to share good osteopathic practice with their peers.

Strongly disagree	Disagree	Agree	Strongly agree
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17. Osteopaths should not let personal beliefs (either political or religious) influence care.

Strongly disagree	Disagree	Agree	Strongly agree
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18. Osteopaths should be transparent in providing appropriate care to patients.

Strongly disagree	Disagree	Agree	Strongly agree
-------------------	----------	-------	----------------

19. Osteopaths should work within the ethical code required by the regulating authority.

Strongly disagree	Disagree	Agree	Strongly agree
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20. Osteopaths should behave honourably in their dealings with colleagues and patients.

Strongly disagree	Disagree	Agree	Strongly agree
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21. Osteopaths should be willing to participate in research to further the knowledge of osteopathy.

Strongly disagree	Disagree	Agree	Strongly agree
-------------------	----------	-------	----------------

22. Osteopaths should willingly cooperate with other healthcare professionals as appropriate.

Strongly disagree	Disagree	Agree	Strongly agree
-------------------	----------	-------	----------------

23. Osteopaths should provide clear written and verbal information to patients as required.

Strongly disagree	Disagree	Agree	Strongly agree
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24. Osteopaths should respect the individuality of patients.

Strongly disagree	Disagree	Agree	Strongly agree
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25. An osteopath should where possible put their patients' interests above their own.

Strongly disagree	Disagree	Agree	Strongly agree
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26. An osteopath should provide the best care possible in their practice.

Strongly disagree	Disagree	Agree	Strongly agree
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27. Osteopaths should disclose concerns about inappropriate care provided by others.

Strongly disagree	Disagree	Agree	Strongly agree
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28. Osteopaths are responsible for following the best appropriate route for patient care.

Strongly disagree	Disagree	Agree	Strongly agree
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29. Osteopaths should provide patients with sufficient time to explain their problem.

Strongly disagree	Disagree	Agree	Strongly agree
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30. Osteopaths should be able to recognise the limits of their own knowledge and expertise.

Strongly disagree	Disagree	Agree	Strongly agree
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31. Osteopaths should be dedicated to their work to provide the best outcomes.

Strongly disagree	Disagree	Agree	Strongly agree
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32. It is important that an osteopath takes responsibility for their professional actions.

Strongly disagree	Disagree	Agree	Strongly agree
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33. Osteopaths should treat everyone fairly.

Strongly disagree	Disagree	Agree	Strongly agree
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34. Osteopaths should where required be able to work effectively as part of a healthcare team.

Strongly disagree	Disagree	Agree	Strongly agree
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Thank you for your time and for participating in this study.

If you would like any further information please contact:

EdD Researcher : Lucy Mackay Tumber at

lucy.mackay-tumber@open.ac.uk

The Island Osteopathic Clinic, 171 Invicta Road, Sheerness, Kent, ME12 2AG

EdD Supervisor : Dr Mark Wareing at

mark.wareing@beds.ac.uk

## Appendix 7

### Osteopath Vignette



Vignette 1: 'The Osteopath'

(Screenshot included with permission from the Actor)

I'm Clare and I'm an osteopath – I've been in practice for more than 20 years so I suppose you could say I've got a lot of experience(!) although actually I feel like I learn new things every day... even after all these years! I've seen a wide range of patients of all ages and with all sorts of presenting conditions and pain and I really like that sort of broad practice where there's real variety and every day is different, and it keeps me fresh.

The practice I work in has grown over the years – we have new graduates coming in to work and learn the skills and that's really nice – you can share what you've learnt along the way..... help them to learn and grow..... it's really satisfying and it also helps me to keep up to date.

One of the biggest things I've learnt over the years is that listening to patients is absolutely key – patients really do hold all the answers, they just don't know it.. ! You can't boil down the answer to sorting out someone's pain just from looking



at muscles and joints, there is a much bigger picture. People's lives, their whole world, play a part in how their bodies function and how well their bodies cope at any given time. And getting to '*know*' your patients is vitally important in getting to the bottom of this. I keep telling the young osteopaths this – I can't tell them enough how important it is to really listen to your patients.....

#### *PAUSE FOR DISCUSSION*

There have been occasions when I've really been quite concerned about a patient,... because they've got some awful stress or difficulties in their life, and I've had to really hold back my own emotions and remember that I can't '*fix everything*' and I'm not sure that people would appreciate me poking my nose in where it's not wanted! What I personally think might not necessarily be the right thing for them – we're all different aren't we?!

At some stages I have had to sit back a bit and allow people to work their own way through things and that can be difficult when you can see them struggling. You inevitably build up a rapport with patients..., you see them going through all sorts of life changes over the years, and in some ways (as far as their body and health is concerned), you almost feel a partnership in their health and well-being.

#### *PAUSE FOR DISCUSSION*

So sometimes it's difficult to know how much you can help people – you always do your best, trying to look at the big picture, giving people support and advice and really getting them to help themselves.

Every single patient is so different and has different needs – each time you see them you have to think about 'what is right this time?'..., 'what is the best

course of action today?'..., 'what does this patient need right here and right now?'... - it's continually trying to do the right thing and being as sure as you can be that what you're doing is the best thing at any given time....

And really trying to provide that right level of care and support for them because sometimes people don't know which way to turn or where to get the right help.

The GP's around here are really good... - we've got to know them quite well here in this practice, but sometimes their hands are really tied .... – there is sometimes little they can do to help people with really chronic pain.....

*PAUSE FOR DISCUSSION*

*End of vignette*

## Patient Vignette



### Vignette 2: 'The Patient'

(Screenshot included with permission from the Actor)

Hello, my name's Mark, I lost my job a few years ago – I was doing an office job so my body wasn't getting worked too hard. Got made redundant, so I had to go back on the tools – that's back on manual work, this was about 3 years ago now, and I've been having much more pain develop since then. It's mostly in the back and lower back, getting awful neck and arm pain at times as well, and it's making it really difficult to do my job that I'm doing at the moment.

I think it must have been a real shock to my body to go back to physical work after having done office work for about 6 years and my body just isn't coping like it used to be able to.

I went to see an osteopath years ago – and actually went a few times for various aches and pains and they always managed to sort me out. I didn't always see the same person – depends on who was around at the time.... I didn't really care who I saw – I was in pain and I just wanted to get it sorted..... Actually, I think the best osteopath I saw was a young woman..... I think she

was probably foreign, Swedish or something like that.... But she was really good – just got down to it and in about two or three sessions the pain was pretty much gone.....

The latest pain I had was in my lower back – and jeez it was awful..... couldn't move..., couldn't sleep....., the pain was absolutely agony..... so I booked up at a different practice because I've moved since I last went and got an appointment within a few days which I guess isn't too bad ....

Well, the osteopath asked me loads of questions but, some of them.... Well, were really personal, you know? And she kept asking all sorts of things and getting a bit snappy with it.....

*(PAUSE FOR DISCUSSION)*

Then she asked me to do a couple of movements..... Wow, it was absolute agony and she didn't seem to notice!! Then she sort of just started prodding me in a few places, moved my legs around a bit and then told me to go home, put some ice on it and booked me in at the end of the week.

I felt very let down by this. Not what I had experienced before at all. I can't tell you how much pain I was in when I got out of there. She didn't do physically that much to me but what she did do must have really stirred it up! I tried to say how much it hurt but she just snapped at me again and said something like "well, things have to hurt before they get better". I can understand that to a degree, but I've never been told that before.....

Then I tried to ask her what she thought was going on, you see, now I'm self-employed and if I can't work I get in real trouble money-wise.....

And you know, she just didn't seem to know or care! She said something like "it's really difficult to know what's going on underneath" or something like that..... so I said to her 'well, you've had a look at it – you must have an

idea.....’ and she said, “look I’m running late – I’ll run some tests when I see you next time” and then pretty much pushed me out the door into the reception!!!

*(PAUSE FOR DISCUSSION)*

I’ve not been treated like that before, I’ve never had anything like that before – when I’ve seen an osteopath before they’ve always done all sorts of funny movements to see, and I guess, what’s moving and what the cause of the pain is ... and they’ve always given me sort of idea of what’s wrong. This time the pain is so bad I’m really worried that this could be the end of me for workwise.....

I tried to say something to the Receptionist but she was having none of it – she was almost as snappy as the osteopath! I’m really not sure she knew what she was doing. You know when you get that feeling, that somebody is really out of their depth? - maybe in it just for the money? – and that’s what I felt about her.

*(PAUSE FOR DISCUSSION)*

*End of Vignette*

## Appendix 8



### Participant Information form for Osteopaths

#### What is the values base of Osteopathy that informs professionalism?

I am writing to ask if you would be prepared to help with a study about your perceptions of professionalism in osteopathy. I am hoping to uncover a theory of what osteopaths, osteopathic students and osteopathic patients perceive to be the attributes of professionalism in osteopathy.

I intend to start by playing one or two video vignettes in which an osteopath and patient talk about their experiences and discuss what thoughts you have about these. I will be analysing all participants' perceptions of professionalism, values and attitudes within osteopathy to draw together a theory of all stakeholders' perceptions of professionalism in osteopathy. In order to gather sufficient information, it may be helpful to gather further data in subsequent, likely shorter, interviews at your convenience when you are present at the college sites in order to capture full opinion.

I would liaise with yourself to find a convenient time when you are already at the Grange teaching site or the LSO Clinic in order to undertake the interviewing. All interviews will be audio recorded on an iPad or Dictaphone and would be expected to last from 30-60 minutes. You have the right to not answer questions during the interview at any point and are free to withdraw from the study by notifying the Principal Investigator (Lucy Mackay Tumber) at any point during the interview or afterwards by email or post. I will transcribe the interviews onto a computer afterwards and email you the transcription for your information and for you to ensure that it is a faithful recording of the interview and that you are happy with the contents. You are free to add information, clarify any areas or indicate particular data that you would like excluded from the final thesis.

The aim of this research is to uncover a theory of professionalism in osteopathy. Your views will help to understand how osteopaths perceive professionalism in practice and what makes it unique to the osteopathic profession. This part of the study is the main investigation into osteopathic professionalism for a Doctorate in Education through the Open University that will form a thesis to be published by the Open University. This research has been approved by the

Open University Human Research Ethics Committee (reference: HREC 2016 2422 Mackay Tumber).

You are not obliged to take part in this research and non-participation does not affect your employment at the LSO in any way. Your understanding of professionalism is not being assessed but I am hoping to build a theory from combining and exploring as many stakeholders' perceptions as possible. Your views would be very important in contributing to an understanding of osteopaths' perceptions of what constitutes professionalism in practice. You will be provided with complete anonymity and any responses used in the final study would be assigned a pseudonym and will therefore not be attributable to you. The data will be kept for the duration of the EdD study and will be destroyed at the end of this period. If you do not wish any responses to be quoted in the final study you are able to indicate this at any point. No personal data is collected at any point.

If you would like to participate in this research, have any queries or would like to discuss any part of this research further then please contact the researcher:

Lucy Mackay Tumber, at [lucy.mackay-tumber@open.ac.uk](mailto:lucy.mackay-tumber@open.ac.uk)

or the Supervisor at:

Dr Mark Wareing at [mark.wareing@beds.ac.uk](mailto:mark.wareing@beds.ac.uk)

Any responses provided will be treated in full confidence.

Thank you very much indeed for your help. If you would like to see a copy of the final report of this research in 2018 then please contact the researcher to indicate your interest at the above email address.

Yours sincerely

Lucy Mackay Tumber  
The Island Osteopathic Clinic, 171 Invicta Road, Sheerness, Kent, ME12 2AG

*Doctoral Supervisor:*  
Dr Mark Wareing  
16 Deene Close, Adderbury, Oxon, OX17 3LD

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## Appendix 9

### Questions for patient focus group:

(these were adapted appropriately for osteopaths and students)

*In an osteopathic consultation, how do you know it's progressing ok?*

*Do you feel there is a set process?*

*Is the process the same every time?*

*Do you feel things are adapted?*

*What or how can the process change?*

How does the fact we put our hands on patients change the interaction with you?

How do you as osteopathic patients work and learn together with osteopaths?

How does engagement happen?

How does partnership work?

How much do you feel you learn about yourselves?

If you have seen different osteopaths, is the way they interact with patients generally the same 'flavour'?

Do you think there is there an 'art' to it?

How does our holistic 'whole body' approach affect our interaction with you?

### Questions for the unfacilitated focus groups:

What is meant by professionalism?

What do you think osteopathic professionalism is?

What is your experience of osteopathic professionalism?

### Questions for final focus group:

How is professionalism manifest through touch?

How does touch enhance the whole patient experience?

How do osteopaths communicate through touch?



## Appendix 10

### Interview and focus groups schedule

#### Individual Interviews

Interview 1	Aileen (Patient)	29/1/17
Interview 2	Harriet (Osteopath)	4/2/17
Interview 3	Finlay (Osteopath)	5/2/17
Interview 4	Henri (Osteopath)	5/2/17
Interview 5	Sarah (Osteopath)	7/2/17
Interview 6	Clara (Osteopath)	7/2/17
Interview 7	Luke (Patient)	8/2/17
Interview 8	Anna (Student)	14/2/17
Interview 9	Sally (Student)	14/2/17
Interview 10	Jo (Student)	14/2/17
Interview 11	David (Student)	15/2/17
Interview 12	Paolo (Student)	15/2/17
Interview 13	Ed (Student)	15/2/17
Interview 14	Paul (Student)	16/2/17
Interview 15	Timothy (Osteopath)	16/2/17
Interview 16	Agatha (Patient)	17/2/17
Interview 17	John (Patient)	17/2/17
Interview 18	Keith (Student)	19/2/17
Interview 19	Wayne (Student)	19/2/17
Interview 20	James (Osteopath)	24/2/17
Interview 21	Jane (Student)	24/2/17
Interview 22	Scarlet (Patient)	8/3/17
Interview 23	Maureen (Patient)	31/3/17
Interview 24	Hope (Osteopath)	2/4/17
Interview 25	Cara (Patient)	3/4/17
Interview 26	Stella (Patient)	4/4/17
Interview 27	Joy (Patient)	4/4/17
Interview 28	Jill (Patient)	4/4/17
Interview 29	Peter (Osteopath)	6/4/17

Student focus group 7/5/17

Student A	Keith
Student B	Ed
Student C	Louise
Student D	Wayne
Student E	Jo
Student F	Freddie
Student G	David

Osteopath focus group 21/5/17

Osteopath A	Sarah
Osteopath B	Finlay
Osteopath C	Clara
Osteopath D	Pauline
Osteopath E	Richard
Osteopath F	Flora

Patient focus group 10/6/17

Patient A	Stella
Patient B	Aileen
Patient C	Maureen
Patient D	Cara
Patient E	Luke

Unfacilitated Student focus group 9-7-17

6 female
3 male

Unfacilitated Patient focus group 15-7-17

3 female
1 male

Unfacilitated Osteopath focus group 21-7-17

1 female
2 male

Final focus group 25/11/17

Osteopath A	Sarah
Osteopath B	Richard
Student A	Anna
Student B	Samuel
Patient A	Maureen
Patient B	Aileen

## Appendix 11

### Codes from initial interviews

<b><u>Code</u></b>	<b><u>Sub-code</u></b>
In-depth	Focus entirely on patient
Acknowledging	
Showing respect	
Responsibility of the patient	
Silence	
Learning as a student	
Safety/quality in practice	Patient vulnerability Gaining information Evaluation/treatment/talking Providing a diagnosis Levels of knowledge practitioner:patient Consent/inclusion/decision-making Making decisions/judgement call
Patient expectations	Dissatisfaction Bad experience
The power of touch	Intimacy
Making a difference	
Responsibility for patient	Being an advocate Safety and patient care Recognising boundaries to responsibility and ability to help patients Being concerned about patients Availability to patients
Caring	Lack of care
Communicating well	Negotiation Non-verbal – positivity Dialogue with patient With other healthcare professionals Checking understanding Danger of sharing experiences

	Educating patients Suggestion rather than order Educating patients badly Communicating badly Being assertive/taking charge
Osteopathy as a vocation not just a job	Reasons for doing osteopathy Osteopathy for making money
Humility	
Pain	
Being caring	Reassurance Being empathetic Calm and gentle Speech and intonation Language
Trust and faith	Humility Confidentiality Confidence Importance of honesty Lack of honesty Lack of faith
Being non-judgemental	Being judgemental Treated with respect
Patient uniqueness and individuality	
Getting help	Getting answers Choice of osteopathy Hoping for a cure/improvement Not being able to help much Positive help
Overall setting	Safe space Seeing the same practitioner
Relationship	Confiding Humour Familiarity

	<p>Rapport</p> <p>Humanity</p> <p>Connection between patient and practitioner</p> <p>Not needing an in-depth relationship</p> <p>Limit of boundaries</p> <p>Bad relationship</p> <p>Intuition and inbuilt reactions</p> <p>Patient needing osteopath more</p> <p>Lack of ease</p> <p>Being treated fairly</p> <p>Not being honest</p> <p>Being talked down to</p> <p>Being made to feel equal</p> <p>Two-way relationship</p> <p>Good relationship</p> <p>Being interested</p> <p>Cultural/age issues</p> <p>Personal implications</p> <p>Osteopath as a role</p> <p>Importance of gender of practitioner</p> <p>Ease</p> <p>Friendship</p>
Talking	<p>Opening up</p> <p>Not wanting to talk</p> <p>Giving time to talk</p> <p>Whether to offer advice</p> <p>Asking questions</p> <p>Not asking questions</p> <p>Boundaries/limitations of questions</p> <p>Importance of keeping on track</p> <p>Talking cure – importance of talking to osteopath for health</p> <p>Manner of speaking</p>
Patient partnership and input	<p>Finding appropriate advice/suitable advice</p> <p>Patients not wanting to help themselves</p>

	Importance of patients helping themselves Looking for answers together
Listening	Not listening Different ways of listening Knowing how to listen Being understood
Time	Ownership of time Time it takes to get better/time to resolve issue Time provided relaxation/me-time Being rushed Lack of time with GP Effect of time with osteopath Agreed time/on-time
Going to the GP due to pain	
Patient learning about their health and making themselves better	Patients educating self Patients having prior knowledge Educating about osteopathy Patient not helping themselves/engaging Understanding holism
Identity of patient as person	
Understanding what the osteopath thinks	Thinking outside the box
Passing on knowledge and teaching new osteopaths	Teaching key skills to students Learning new knowledge and keeping up to date
Patient holds the key to their health	Looking for answers Patient as the answers but doesn't know it
Osteopath interested in the patient as a person	Knowledge about patients Learning from the patient Interested in variety of patients Patient awareness of osteopath as a person Patient awareness of whole context Looking at the whole picture Lack of holistic view

<p>Osteopath originality and autonomy</p>	<p>General Osteopathic Council</p> <p>Appearance/clothing</p> <p>Osteopathic philosophy</p> <p>Lack of differentiation of osteopathy</p> <p>Lack of frameworks/protocol</p> <p>Level of experience and expertise</p> <p>Variance between types of osteopathy</p> <p>Connecting with other osteopaths</p> <p>Learning from others</p> <p>Lack of integration with other healthcare</p> <p>Gaining integration with other healthcare</p> <p>Lack of skill</p> <p>Level of knowledge</p> <p>Learning through practice</p> <p>Referring patients on</p> <p>Limitations of evidence base</p> <p>Limitations of knowledge and/or skill</p> <p>Osteopath reflection/self-reflection</p> <p>Importance of qualifications</p> <p>Recommending the osteopath</p>
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## Appendix 12

Aileen (Patient), Interview 29/1/17, page 1 line 20 – page 2 line 37.

Interviewer: What do you make of that? #00:01:56-6#	
Respondent: I think it's interesting that you don't think of the osteopath having their own thoughts and ideas, so I think that it's interesting the fact that they're interested in you as a person and what you are actually thinking but they also think you hold the key to your own problems. Which in effect you do in as much as when you're treated, if you are given exercises, you hold that key, so I find that, that's interesting the fact that it's been thought about from the patient's side as well. But also, explaining to young osteopaths I think is good, that you're passing on knowledge that is sensible and reasonable. Very good. #00:02:43-0#	Osteopath originality and autonomy. Osteopath interested in the patient as a person. Patient holds the key to their health. Osteopath interested in the patient as a person. Passing on knowledge and teaching new osteopaths.
Interviewer: That hasn't come across to you before as a patient that, that, the whole picture is being looked at? #00:02:51-8#	
Respondent: Erm, I think it has to a certain degree but listening to somebody actually saying it reinforces that belief. I think in the back of your mind it would be there but hearing and seeing somebody say it makes a difference because then you learn that, you know, somebody is thinking outside the box. You know, although you are patient, in inverted comas, you are also a person underneath - a person in pain - and you have your own answers but you don't know it, so in a way it's like you're learning - you're learning to treat yourself which is a good thing - I think it's a very good thing. #00:03:38-6#	Looking at the whole picture. Understanding what the Osteopath thinks. Thinking outside the box. Identity of patient as person in pain. Patient has the key to their health/Patient doesn't know it. Patient learning about their health and making themselves better.
Interviewer: Yeah. And are you aware of if you go to see other health practitioners that that's going on? #00:03:45-7#	
Respondent: Erm, I suppose, in a sense, if I was going to the GP, again you're in the situation where you're in pain but I always would feel that you've got a certain amount of time and they want you out, whereas with the osteopath the time is longer so you're more relaxed about actually talking and saying the things. You don't feel you've got to rush with the osteopath. You don't feel like you've got five minutes to explain your problem and then you're out the door -	Going to the GP due to pain. Time – lack of time with GP. Time – effect of time with Osteopath. Time – relaxation/'me' time. Being rushed – not feeling rushed.

<p>you don't feel that. You feel that the osteopath's got the time to listen to you because part of their experience is listening to you. They need to listen to you to be able to help you. #00:04:31-8#</p> <p>Interviewer: Does the GP not need that as well? #00:04:32-3#</p> <p>Respondent: He does but he hasn't got the time because outside his door he's got another twenty patients - outside the osteopath's door they probably haven't got anybody for a majority of that time. So they're not thinking, subconsciously, I've got to get to the next patient, you know, so if you're going with something that they would consider was minor then they might be, the next person it might be major, so they're already into, probably, the next patient mode rather than you. I think the osteopath just gives you the time - the time to think, the time to realise that, you know, you can be helped. If you like they give you that talk to make you feel that if you do this that and the other you are going to be made well again, but you're right, with the GP they, with the best will in the world, they have so little time to give you. #00:05:40-3#</p> <p>Interviewer: So there's an element of feeling stressed before you go in, when you know there's a time constraint, and you don't feel that with osteopaths? #00:05:47-8#</p> <p>Respondent: No - that's exactly right. If I was going to the GP, I probably would have to be sitting there waiting longer to go in, so you have that build-up of tension. You have the build-up of trying to remember everything you want to say and then when you are sitting there it's trying to say what you want to say, erm, within a very short span of time. The osteopath - you don't have that because you are coming at an agreed time, very seldom would they not see you on time and you know that there is nobody sitting out there so you're not sort of thinking that I've got to say this or I've got to say that. I think it's a time thing with the osteopath - it is the fact that they give you time and I think a lot of people actually like to have time to sit down, you know, just relax, just talk, erm and I think osteopathy, some of it is a talking cure which obviously, you know, a lot of people find comforting. #00:07:02-5#</p> <p>Interviewer: That's good. We'll listen to the next bit. #00:07:02-7# #00:07:03-7#</p>	<p>Knowing how to listen. Listening – being understood.</p> <p>Time – lack of time with GP. Effect of time with Osteopath/agreed time – on time. Time – being rushed. Focus not on the Patient.</p> <p>Effect of time with Osteopath. Patient partnership and input. Time to think – giving space. Lack of time with GP.</p> <p>Lack of time with GP. Lack of ease. Not having enough time. Feeling stressed. Effect of time with Osteopath – agreed time/on time. Giving time to talk.</p> <p>Time providing relaxation/'me' time. Talking cure – importance of talking to Osteopath for health.</p>
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**Results from Pilot Study**

**Compassion**

Title	Number	Mean Rank
Osteopath	8	16.56 <sup>ab</sup>
Student Osteopath	8	10.17 <sup>a</sup>
Osteopathic Patient	13	19.65 <sup>b</sup>

**Osteopaths should disclose concerns about inappropriate care provided by others**

Title	Number	Mean Rank
Osteopath	8	8.50 <sup>a</sup>
Student Osteopath	8	18.50 <sup>b</sup>
Osteopathic Patient	13	16.85 <sup>b</sup>

**Osteopaths should be prepared to show leadership where required**

Title	Number	Mean Rank
Osteopath	8	9.94 <sup>a</sup>
Student Osteopath	8	17.63 <sup>b</sup>
Osteopathic Patient	13	16.50 <sup>b</sup>

**Working to the Osteopathic Practice Standards**

Title	Number	Mean Rank
Osteopath	8	15.56 <sup>ab</sup>
Student Osteopath	8	8.94 <sup>a</sup>
Osteopathic Patient	13	21.19 <sup>b</sup>

**Osteopaths should behave honourably in their dealings with colleagues and patients**

Title	Number	Mean Rank
Osteopath	8	13.25 <sup>ab</sup>
Student Osteopath	8	10.63 <sup>a</sup>
Osteopathic Patient	13	18.77 <sup>b</sup>

**Osteopaths should be willing to participate in research to further the knowledge of osteopathy**

Title	Number	Mean Rank
Osteopath	8	9.63 <sup>a</sup>
Student Osteopath	8	17.31 <sup>ab</sup>
Osteopathic Patient	13	16.88 <sup>b</sup>

*(N.B. a and b indicate where mean scores flagged with the same letter are not significantly different from each other, whereas mean scores flagged with different letters appear significantly different from each other).*

## Appendix 14

### Internal Consistency for Pilot Study

#### Reliability Statistics for Values

Cronbach's Alpha	Cronbach's Alpha based on Standardised Items	Number of Items
.911	.911	17

#### Reliability Statistics for Attitudes

Cronbach's Alpha	Cronbach's Alpha based on Standardised Items	Number of Items
.926	.927	34